

IDAHO PIPE TRADES TRUST
F 34
REQUEST FOR RESTRICTIONS ON THE USE AND/OR DISCLOSURE OF PHI

Participant Name: _____ Birth Date: ____/____/____
MM / DD / YR

Address: _____

Home Telephone Number: _____ E-mail: _____
Participant Identification Number and/or Social Security Number: _____

I, _____, am requesting that the above Trust restrict the use and/or disclosure of my health information (information that constitutes protected health information as defined in the Privacy Rule of the Administrative Simplification provisions of the Health Insurance Portability and Accountability Act of 1996) in the manner described below. I understand that the Trust may deny this request for any reason. I also understand that if agreed to, the Trust may not be able to honor this request if I require emergency treatment and that the Trust may remove this restriction in the future, if I am notified in advance.

Description of Restriction of the Health Information to be Used or Disclosed. The following is a description of the specific health information I wish to restrict:

Persons/Organizations Restricted from Use and/or Disclosure of Health Information. I request that the following person(s) and/or organization(s) not be allowed to use, receive and/or disclose the health information described above.

By signing this form, I am confirming that it accurately reflects my wishes.

_____/_____/_____
Signature Date

If signed by personal representative:

Name of personal representative: _____

Relationship to participant or nature of authority: _____

_____/_____/_____
Signature of Personal Representative Date