INDIVIDUAL REQUEST FOR RESTRICTIONS ON USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

I understand that the Loyola University New Orleans Employee Benefit Plan ("Health Plan") may use and disclose **protected health information about me for purposes of health care treatment, payment and health care operations without my consent.** I request the Health Plan to restrict the use and disclosure of certain protected health information about me in accordance with the Health Insurance Portability and Accountability Act of 1996, as amended (HIPAA).

Health Plan Not Required To Agree: I understand that the Health Plan is not required to agree to this restriction unless: (i) the disclosure is to a health plan for purposes of payment or health care operations (not for purposes of carrying out treatment) and not otherwise required by law, and (ii) the protected health information pertains solely to a health care item or service for which the health care provider has been paid out of pocket in full.

Termination of Restriction: I understand that if the Health Plan agrees to this restriction, either the Plan or I may terminate this restriction at any time (except that the Health Plan may not unilaterally terminate a restriction on the disclosure of PHI for purposes of payment or health care operations, pertaining solely to a health care service or item for which the health care provider has been paid out of pocket in full). The termination of the restriction is only effective for future uses and disclosures occurring after the Plan receives this request.

If the request is to not disclose information to a health plan for payment or health care operations and the health care provider has been paid in full check here. ☐

Emergency Treatment Exception: I understand that if protected health information must be used or disclosed to provide emergency treatment for me, then this restriction is void.

Required Information: Please provide all of the following information. If not applicable, mark N/A on the answer line.

(1) I request the following information be restricted [description of information]:

_____

(2) I request that use and disclosure of the above-described information be restricted in the following manner [description of restriction]:

_____

_____

(3) I request that my protected health information not be disclosed to the following individuals or entities [list individuals or entities to which information would not be disclosed]:

_____

_____

I understand that if a restriction is not specifically listed above and agreed to in writing by the Health Plan, it will not be effective. Please mail or fax the completed Form to**:** Donna Rochon, Privacy Officer for the Loyola University New Orleans Employee Benefit Plan, Human Resources Department, Loyola University New Orleans, 6363 St. Charles Avenue, Campus Box 16, New Orleans, LA 70118, 504.864.7272 (phone), 504.864.7100 (fax)**.**

Signature: _____ Date: _____

Date of Receipt by Plan: _____

Form G