HB-0628-0522

State Health Benefits Program (SHBP) • School Employees' Health Benefits Program (SEHBP)

PARTICIPANT REQUEST FOR RESTRICTIONS ON THE USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

Participant Name _____
Last *First* *Middle Initial*

Address _____
Street *City* *State* *Zip Code*

Phone Number _____ Email _____

Participant Identification Number or Social Security Number _____

I, _____, am requesting a restriction on the State Health Benefits Program's (SHBP) or School Employees' Health Benefits Program's (SEHBP) use and/or disclosure of my health information (Protected Health Information as defined in the Privacy Rule of the Administrative Simplification provisions of the Health Insurance Portability and Accountability Act [HIPAA] of 1996) in the manner described below. I understand that the SHBP/SEHBP may deny this request for any reason. I also understand that, if agreed to, the SHBP/SEHBP may not be able to honor this request if I require emergency treatment and that the SHBP/SEHBP may remove this restriction in the future if I am notified in advance.

The following is a description of the specific health information I wish to restrict _____

_____

_____

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 _____

_____

Participant's Signature (By signing this form, I am confirming that it accurately reflects my wishes.)

_____ _____/_____/_____
Participant's Signature *Date*

If signed by a personal representative, complete the following:

Name of personal representative _____

Relationship to participant or nature of authority _____
(e.g. health care power of attorney, guardian, other authorization — A copy of documentation must be attached.)

Address _____
Street *City* *State* *Zip Code*

Phone Number _____ Email _____

_____ _____/_____/_____
Signature of Personal Representative *Date*

Return completed form to:

HIPAA Privacy Officer
SHBP/SEHBP
P.O. Box 295
Trenton, NJ 08625-0295