BlueCross BlueShield | FEPBlueVision

# RESTRICTION REQUEST

***Member Information***

*(Please Print)*

This section must be completed with the information specific to the individual. A contact number or address is needed in case additional information or clarification is required.

**Date:** _____ **Member ID:** _____

**Name:** _____ **Date of Birth:** _____

**Address:** _____ **Telephone:** _____

_____ **Email:** _____

**You have the right to request that FEP BlueVision® restrict the use or disclosure of your protected health information for treatment, payment or health care operations or to persons involved in your care or payment for that care. FEP BlueVision® is under no obligation to agree to your request. If FEP BlueVision® does, the agreement must be in writing and FEP BlueVision® will then restrict the use or disclosure of your protected health information as you request. FEP BlueVision® may, notwithstanding the agreement, use or disclose the restricted information needed for your treatment in an appropriate medical emergency, or when the use or disclosure without your written permission is authorized or required by law. You may end the restriction at any time by notifying FEP BlueVision® in writing. FEP BlueVision® may end the agreement to restrict use or disclosure of your protected health information at any time by notifying you in writing. If you agree with the decision to end the restriction, your protected health information will no longer be subject to the restriction. If you disagree, the termination of the restriction will apply only to your protected health information that FEP BlueVision® creates or receives after giving you notice that we are terminating the restriction. To exercise your right to request restriction on FEP BlueVision's® use or disclosure of your protected health information, please complete this form, sign and submit to:**

**FEP BlueVision® – Privacy Office**
**P.O. Box 1416**
**Latham, New York 12110-1416**
**Fax: 1-866-999-4640**

**If you have questions, need additional information or assistance in completing your request, please contact the FEP BlueVision® Privacy Office at 1-800-571-3366 or the address shown above.**

Please specify the protected health information, the use or disclosure of which you want to restrict:

_____

_____

_____

Please state the restriction you want to apply to that protected health information:

_____

_____

_____

**Signature:** _____ **Date:** _____

*(Person Granting Authorization)*

If this authorization is signed by a personal representative on behalf of the individual, complete the following:

**Personal Representative's Name:** _____

*(Please Print)*

**Description of Personal Representative Authority:** _____

**PLEASE RETAIN A COPY OF THIS REQUEST FOR RESTRICTION FOR YOUR RECORDS**