Privacy Restriction Request Form

Mid-America Carpenters Regional Council Health Fund (Fund)
St. Louis-Kansas City Region
1419 Hampton Avenue, St. Louis, MO 63139 *Attn: HIPAA Privacy Officer*
Phone: (314) 644-4802, option 1 | Fax: (314) 678-1110 | Email: benefits@laborfunds.org

Reset form

Complete electronically or print clearly using black or blue ink. This form requires you to print, sign, and return to our office.

Complete one form per individual requesting to restrict their Protected Health Information (PHI) / (ePHI).

SECTION 1: COVERED INDIVIDUAL INFORMATION

Covered Individual Full Name (Last, MI, First)	Last 4 Social Security Number (SSN) or UMR/UHC ID

Relationship to Participant: ☐ Participant ☐ Spouse ☐ Dependent

Date of Birth	Cell Phone Number	Email Address

SECTION 2: PRIVACY RESTRICTION REQUEST

The Fund Office does not have my permission to discuss my protected health information with:

☐ My Spouse: Name of Spouse: _____

☐ My Parent(s) or Legal Guardian(s)
This option only applies to Health Plan covered dependents.

SECTION 3: COVERED INDIVIDUAL ACKNOWLEDGEMENT AND SIGNATURE

By completing and signing this form, I understand and agree I am now restricting my PHI/ePHI to the person(s) or entity(oes) listed above. I also understand that this restriction will not affect any action the Fund may have already taken in reliance on my authorization before they receive this written notice.

X _____ _____

Covered Individual Signature Date

Mail, fax, or email this completed form to the address at the top of this form, Attn: HIPAA Privacy Officer.