



**STATE OF LOUISIANA - OFFICE OF GROUP BENEFITS
REQUEST FOR RESTRICTION OF PROTECTED HEALTH INFORMATION**



I hereby request a restriction to the Office of Group Benefits'(OGB) uses and disclosures of my protected health information.

MEMBER/DEPENDENT NAME		DATE OF BIRTH		MEMBER ID NUMBER OR LAST 4 DIGITS OF SSN	
ADDRESS			CITY		STATE
					ZIP CODE
EMAIL ADDRESS			TELEPHONE (PRIMARY)		TELEPHONE (ALTERNATE)
WHAT INFORMATION DO YOU WANT TO BE COVERED BY A RESTRICTION?					
WHAT USES AND/OR DISCLOSURES DO YOU NOT WANT OGB TO MAKE?					
HOW LONG DO YOU WANT THIS RESTRICTION TO REMAIN IN EFFECT?					
WHY DO YOU WANT OGB TO AGREE TO THIS RESTRICTION?					

I understand that the Office of Group Benefits (OGB) will review the request and that the restriction may be denied by OGB.

SIGNATURE OF HEALTH PLAN MEMBER/DEPENDENT OR REPRESENTATIVE

DATE

Request is (circle one):

APPROVED

DENIED

EXPIRATION DATE OF RESTRICTION (IF ANY)

SIGNATURE OF OGB REPRESENTATIVE

DATE

TITLE OF OGB REPRESENTATIVE
