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' uses and disclosures of my protected health information:

Health Plan Member/Dependent Name: ____________________

Date of birth: ____________________ **Telephone:** _____________________

Address: _____________________________________
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Member Number: _______________________________

What information do you want to be covered by a restriction? ____________________________
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What uses and/or disclosures do you not want us to make? ______________________________
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How long do you want the restriction to remain in effect? _______________________________

Why do you want us to agree to this restriction? _______________________________________
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I understand that the Office of Group Benefits will review the request and that the restriction may be denied in the sole discretion of the Office of Group Benefits.

Signed: ______________________________________ Date:________________
Signature of Health Plan Member/Dependent
or Representative

Approved Denied (Circle one)

Expiration date of restriction (if any): ____________________________

Signed: ____________________________________ Date:________________

Title: ______________________________________