REQUEST TO RESTRICT USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

Participant's Identification Number or Social Security Number: ______________________________

Participant's Name: ______________________________

Your Name (if you are not the Participant): ______________________________

Your relationship to the Participant (if you are not the Participant): ______________________________

Describe the restriction you would like placed on your health information:

Effective date of your authorization: ______________________________

Expiration date of your authorization: ______________________________

Today's date: ____________________ Your signature: ______________________________

Print Name: ______________________________

TeamCare will make every attempt to comply with all reasonable requests for restrictions on the use and disclosure of your protected health information. If we are unable to comply your request, you will be notified.

Please mail the completed form to:

Privacy Officer
TeamCare
PO Box 5125
Des Plaines IL 60017-5125

Or fax to: 847-518-9789