SALUS

REQUEST FOR RESTRICTION ON THE USE OR DISCLOSURE OF INFORMATION

Purpose: This form is used to request a restriction on the use or disclosure of information pertaining the individual requesting the restriction.

SECTION A: Person requesting the restriction on the use or disclosure of information:

Name: _____

Address: _____

Phone Number: _____ Email: _____

Medical Record Number: _____

TO THE REQUESTER: Please read the following text and provide the information required.

You are entitled to request that we restrict the use or disclosure of your information. We are not required to accept your request. If we decide to honor your request, it will be done in writing. Despite our agreement, we may use or disclose any restricted information when needed in case of an emergency or when required or authorized by law.

This restriction agreement may be terminated at any time through written notice. If you agree with our decision to terminate the agreement, your information will no longer be subject to the restriction. If Salus unilaterally terminates the restriction, the termination will be prospective. This means it will apply to the information we create or receive after the effective date of the termination notice.

SECTION B: Requested Restriction.

Please specify the information whose use or disclosure you wish to restrict.

_____

_____

Please state the restriction you wish to place on the information.

_____

_____

SIGNATURE OF REQUESTER. YOU ARE ENTITLED TO RECEIVE A COPY OF THIS REQUEST.

Signature: _____ Date: _____

If this document is signed by a personal representative on behalf of the insured person, please provide:

Name of Personal Representative: _____

Relationship to the Insured Person: _____