PWGA
Pension & Health Plans
YOUR TRUSTED GUIDE

REQUEST FOR RESTRICTIONS/REVOCATION ON USE AND/OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

I understand that the Writers' Guild-Industry Health Fund ("Fund") may use and disclose protected health information (PHI) about me for purposes of treatment, payment, and health care operations without my authorization or opportunity to agree or object. I am requesting the following actions on use and/or disclosure of my **P**rotected **H**ealth **I**nformation ("PHI" as defined in the Privacy Rule of the Health Insurance Portability and Accountability Act of 1996), in the manner described below. I understand that the Fund may deny my request, including without limitation the feasibility of accommodating the request, additional costs to the Fund, etc. You will be contacted if your request is denied or cannot otherwise be accommodated.

This request must be completed in full before being submitted

PARTICIPANT/DEPENDENT INFORMATION			
NAME		ID NUMBER	
STREET ADDRESS	CITY	STATE	ZIP CODE
PHONE NUMBER	EMAIL ADDRESS		

☐ **RESTRICTION OF DISCLOSURE OF PHI***　　☐ **REVOCATION OF DISCLOSURE OF ALL PHI****

*ADD DESCRIPTION OF RESTRICTION OF HEALTH INFORMATION TO BE USED OR DISCLOSED AND PERSON/ORGANIZATIONS TO BE RESTRICTED OR REVOKED FROM USE AND/ OR DISCLOSURE OF "PHI".
**I UNDERSTAND THAT THE FUND IS NOT REQUIRED TO AGREE TO REQUESTED RESTRICTIONS, WITH ONE EXCEPTION. THE FUND WILL AGREE TO A REQUEST TO RESTRICT DISCLOSURE OF MY PHI TO A HEALTH PLAN IF: (A) THE DISCLOSURE IS FOR THE PURPOSE OF CARRYING OUT PAYMENT OR HEALTH CARE OPERATIONS (I.E., NOT FOR TREATMENT) AND IS NOT OTHERWISE REQUIRED BY LAW; AND (B) THE PHI PERTAINS SOLELY TO A HEALTH CARE ITEM OR SERVICE FOR WHICH I, OR SOMEONE (OTHER THAN THE FUND) ACTING ON MY BEHALF, HAS PAID IN FULL."

The following is a description of the specific health information I wish to restrict:

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PERSONS/ORGANIZATIONS TO BE RESTRICTED OR REVOKED FROM USE AND/OR DISCLOSURE OF PHI

I am requesting the following person(s) and/or organization(s) not be allowed to use, receive, and/or disclose the health information described above.

NAME OR COMPANY NAME			
STREET ADDRESS	CITY	STATE	ZIP CODE

By signing this form, I understand that if restricted PHI must be used or disclosed to provide emergency treatment for me, then this restriction is void. I understand that if the Fund agrees to a restriction, either the Fund or I may terminate this restriction at any time (except the Fund will not terminate any restriction that is required by law). If the Fund informs me that it is terminating its agreement to a restriction, the termination of the restriction is only effective with respect to PHI created or received after the Fund informs me of the termination.
I understand that if a restriction is agreed to by the Fund, it is not effective to prevent uses or disclosures required by the Secretary of the U.S. Department of Health and Human Services to investigate the Plan's compliance with HIPAA or uses or disclosures that are otherwise required by law. I understand that if a restriction is not specifically listed above and agreed to in writing by the Plan, it will not be effective.

____　　_____/_____/_____

Participant Signature　　Signature Date

If this request for the Restrictions or Revocation of PHI is to be signed by a personal representative, that personal representative must also sign below before submitting this form to the Fund.

If signed by personal representative, name of personal representative: ______________________________

Relationship to Participant or nature of authority: ______________________________　____/_____/_____

Signature of Personal Representative　　Date