Michigan Conference of Teamsters Welfare Fund
Individual Request for Restrictions on Use and/or Disclosure of Protected Health Information

Section #1: Individual Information

I certify that I am (check all that apply):

☐ A participant (employee/retiree)

☐ A participant's spouse or surviving spouse

☐ A non-spousal dependent of a participant

☐ A personal representative*

Name of Participant: _____ _____
(print name)

Participant's Contract Number: _____-_____-_____ Participant's Birth Date: _____/_____/____
MM / DD / YR

You can contact me at:

Home Telephone Number: _____ E-mail: _____

Work Telephone Number: _____

I am requesting a restriction on the use and/or disclosure of health information for (check only one):

☐ Myself (print name)_____

☐ My dependent minor child (print name)_____

☐ A covered individual for whom I am the personal representative* (print name)_____

**Note: If you are a personal representative of the individual and you are completing this form on behalf of the individual, you must complete the personal representative area found in Section #3. Personal representative means a person with legal authority (under State or applicable law) to act on behalf of the individual in making health care decisions.*

Section #2: Restriction on Use and/or Disclosure

I, _____ (print name), am requesting a restriction on the Michigan Conference of Teamsters Welfare Fund's (MCTWF) use and/or disclosure of health information (information that constitutes protected health information as defined in the Health Insurance Portability and Accountability Act of 1996) for the identified individual in Section #1. I understand that MCTWF may deny this request for any reason. I also understand that if agreed to MCTWF may not be able to honor this request if emergency treatment is required and that MCTWF may remove this restriction in the future, if I am notified in advance. I also understand that if agreed to, this restriction may prohibit MCTWF from being able to effectively process my claim payment.

Description of Restriction of the Health Information to be Used or Disclosed. The following is a description of the specific health information I wish to restrict:

_____

_____

_____

Michigan Conference of Teamsters Welfare Fund
Individual Request for Restrictions on Use and/or Disclosure of Protected Health Information

Persons/Organizations Restricted from Use and/or Disclosure of Health Information. I request that the following person(s) and/or organization(s) not be allowed to use, receive and/or disclose the health information described above.

_____

_____

I, _____ (print name), have reviewed this form and understand its contents. By signing this form, I am confirming that it accurately reflects my wishes.

_____ _____/_____/_____ Date of Signature
Signature MM DD YY

Address: _____

_____

Section #3: Personal Representative

If signed by a personal representative, complete the following:

Name of personal representative: _____
(print name)

Name of individual you are representing: _____
(print name)

Relationship to individual or nature of authority (e.g., parent of an unemancipated minor, unlimited guardian pursuant to letters of authority, personal representative pursuant to letters of authority, parent advocate pursuant to a health care power of attorney, other statutory authorization): _____

Note: You must provide valid and current proof of your legal relationship as a personal representative.

Personal Representative Contact Information

Address: _____

_____

Home Telephone Number: _____ E-mail: _____

Work Telephone Number: _____

_____ _____/_____/_____ Date of Signature
Signature of Personal Representative MM DD YR

Section #4: Submission Instructions

Submit Form to: Privacy Officer
Michigan Conference of Teamsters Welfare Fund
2700 Trumbull Avenue
Detroit, MI 48216