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

Section #1: Individual Information

Name _____ Birth Date _____/_____/_____
Please Print MM / DD / YR

Contract Number _____ or Social Security Number _____
(Found on ID card)

Address _____

City _____ State _____ ZIP Code _____

Telephone Number _____ E-mail _____

Section #2: Restriction on Use and/or Disclosure

I hereby request a restriction on the Michigan Conference of Teamsters Welfare Fund's (the Fund) 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 the Fund may deny this request for any reason. I also understand that if agreed to, the Fund may not be able to honor this request if emergency treatment is required and that the Fund may remove this restriction in the future, if I am notified in advance. I also understand that if agreed to, this restriction may prohibit the Fund 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:

_____

_____

_____

Section #3: Person or Entity Restricted from Use and/or Disclosure

I request that the Fund not disclose to the following person and/or entities (or classes of persons and/or entities) the health information described in Section #2.

Person or Entity Name _____ _____ Telephone Number_____

Address_____

City _____ State _____ ZIP Code_____

☐

Section #4: Authorization and Signature

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 / YR

Address_____

City _____ State _____ ZIP Code _____

☐ I am the personal representative for the member.*
**Note: If you are a personal representative of the individual and you are completing this form on behalf of the individual, you must complete Section #5. 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 #5: 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., health care power of attorney, guardian, other statutory authorization):

_____*Note: If other than natural parent of a minor child, valid and current proof of legal relationship as personal representative must be provided.*

Personal Representative Contact Information

Address: _____ Telephone Number: _____

_____ E-mail: _____

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

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

Or Fax to: ***313-496-2943***