PUBLIC SAFETY/CORP CANCER INSURANCE POLICY PROGRAM
REQUEST FOR RESTRICTION OF PROTECTED HEALTH INFORMATION (PHI)
APN: HIP-009 (07/2021)

Participant Name: **Participant ID #:**

Public Safety/Corp Cancer Insurance Policy Program, as allowed by law, may use or disclose your health information:

1. For purposes of treatment, payment, or health care operations.
2. To someone involved in your care or the payment for your care, such as a family member, friend, or relative.

This form allows you to request restrictions on the use and disclosure of your health information within either of the above purposes.

As such, I hereby request Public Safety/Corp Cancer Insurance Policy Program to restrict the use and disclosure of my health information in following manner:

Information to be restricted:

Reason for restriction:

Please indicate the individual, care provider, or any legal representative to whom access should be denied.	
Individual's Name	**Relationship to You**

I understand that:

1) Public Safety/Corp Cancer Insurance Policy Program is not required by law to accept my requested restrictions, but if it does, Public Safety/Corp Cancer Insurance Policy Program agrees to abide by the restrictions except in emergency situations.
2) This agreement to restrict use and disclosure does not prevent uses or disclosures made for the following purposes:
    a. For the facility directory
    b. In the event of an emergency situation
    c. As required by law
    d. For certain public health activities
    e. For reporting information to law enforcement officials or state agencies about victims of abuse, neglect, domestic violence, or other crime
    f. For health oversight activities or law enforcement investigations
    g. For judicial or administrative proceedings
    h. For identifying decedents to coroners and medical examiners, including determining cause of death
    i. For organ procurement
    j. For certain research activities
    k. For workers' compensation programs
3) Either I or Public Safety/Corp Cancer Insurance Policy Program may terminate this restriction in writing at any time in the future.

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Signature: *(Participant, Your 'Typed' First and Last Name Constitutes Your Signature)*

Date

Printed Name of Participant's Representative (*if applicable*)

Relationship to Participant (*if applicable*)

☐ Executor or administrator of decedent's estate
☐ Power of Attorney

Submit Form

FOR OFFICE USE ONLY

Request Accepted ☐ Denied ☐

Reason for Denial (*if applicable*)