

**PUBLIC SAFETY/CORP CANCER INSURANCE POLICY PROGRAM**  
**REQUEST FOR RESTRICTION OF PROTECTED HEALTH INFORMATION (PHI)**  
 APN: HIP-009 (12/2022)

**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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**Date**

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

**Relationship to Participant** *(if applicable)*

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

Executor or administrator of decedent's estate  
Power of Attorney

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**\*\* For Office Use Only \*\***

**ID Verification Completed By:**

**Date Verification Completed:**

*(MM DD YYYY format)*

**Notes:**

**Request**    Accepted    Denied

**Reason for Denial** *(if applicable)*