Wellmark Advantage Health Plan, Inc. is an independent licensee of the Blue Cross and Blue Shield Association.

Request for Restriction of Use and Disclosure of Protected Health Information

Use this form to request a restriction of our use and disclosure of your protected health information that we, or our business associates, maintain for treatment, payment or health care operations, to persons involved in your care, or payment for that care.

Please complete the following:

Name			Daytime phone number
Address			
City	State	ZIP code	Enrollee ID

Please read and complete the following:
You have the right to request that we restrict our use and disclosure of your protected health information for treatment, payment and health care operations to persons involved in your care, or payment for that care. We are not required to grant your request. If we do, our agreement will be in writing and we will restrict our use and disclosure of your protected health information as you request. We may, however, use and disclose the restricted information in appropriate medical emergency situations, or when use or disclosure without your written permission is authorized or required by law.

You can terminate the restriction at any time by notifying us in writing. We can also terminate our agreement to a restriction at any time by notifying you in writing. If we do, termination is effective only to protected health information that we create or receive after we gave you our written notice terminating the restriction.

To exercise your right to request a restriction on our use and disclosure of your protected health information, please specify the protected health information you want to be handled in a restricted fashion, and the restrictions you want us to apply:

Please sign and date:
I request that you restrict the use and disclosure of my protected health information as specified above. I understand that you are not required to agree to my request, but if you do, you will inform me of any termination of the restriction in writing.

_______________________________ *Signature*

_______________________________ *Date*

If you are not the patient, please sign and date this form below. Check the box that describes your relationship to the patient. **If you are not the parent of the patient, please attach proof of your relationship to the member (e.g., power of attorney, personal representative documentation, etc.).**

Print name of personal representative: _______________________________

Signature of personal representative and date: _______________________________

☐ Parent of minor child ☐ Legal guardian ☐ Power of attorney ☐ Executor ☐ Other

Please include the fax number as shown below.
Please mail completed form (and all documentation if needed) to: **Customer Individual Rights Unit**
600 East Lafayette, MC 1620
Detroit, MI 48226-2998
or Fax to: **1-877-522-4767.**