Individual request not to use or disclose (restrict) health information or to end restriction on use or disclosure of health information maintained by BlueAdvantage Administrators of Arkansas

I understand that BlueAdvantage Administrators of Arkansas, a third-party claims administrator providing services for my Employer's Group Health Plan, may use and disclose protected health information about me for purposes of health care treatment, payment, and health care operations without my consent. I request to restrict use and disclosure of protected health information concerning health care treatment, payment, or health care operations about me by BlueAdvantage Administrators of Arkansas in accordance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

BlueAdvantage Administrators Not Required to Agree
I understand that my Employer's Group Health Plan and BlueAdvantage Administrators are not required to agree to this restriction.

Termination of Restriction
I understand that if my Employer's Group Health Plan and BlueAdvantage Administrators of Arkansas agree to this restriction, the Group Health Plan and BlueAdvantage Administrators of Arkansas or I may terminate this restriction at any time. The termination of the restriction is only effective for future uses and disclosures.

Emergency Treatment Exception
I understand that if protected health information must be used or disclosed to provide emergency treatment for me, than this restriction is void.

Questionnaire
Please complete all of the following questions. If the question is not applicable, mark N/A on the answer line.
☐ Restriction ☐ Discontinue restriction

(1) I request the following information (description of information) be restricted / released from restriction:

_____

(2) I request that use and disclosure of the above described information be restricted in the following manner (description of restriction):

_____

(3) I request that my protected health information not be disclosed to the following individuals or entities (List individuals or entities to which information would not be disclosed):

_____

I understand that if a restriction is not specifically listed above and agreed to in writing by the group health plan, it will not be effective.

Termination of Restriction
☐ I request that the restriction described above be removed and all information available for treatment, payment and health care operations.

First name	**Middle initial**	**Last name**	**Member ID**

Address	**City**	**State**	**ZIP**

Signature	**Date signed** (mm/dd/yyyy)

Send completed form to your employer's Human Resources or Benefits Administration Office.