Lucas County

INDIVIDUAL REQUEST NOT TO USE OR DISCLOSE HEALTH INFORMATION

I understand that the Lucas County Health/Dental/Prescription group health plans 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

the_____ [Name of Plan] group health plan in accordance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

Please indicate your request for restricted uses and disclosures of your PHI.

_____

_____

_____

Lucas County is not required to agree to any restrictions requested by an employee, however any restrictions agreed to by Lucas County are binding on Lucas County

Signature:_____ Date:_____