TRIPLE-S SALUD
BlueCross BlueShield of Puerto Rico

RESTRICTION REQUEST

Purpose: This form is to be used for an individual's request to restrict our use or disclosure of protected health information for treatment, payment or health care operations, or with specified persons involved with the individual's care or payment for care.

SECTION A: Individual requesting restriction.

Name: _____

Address: _____

Telephone: _____ E-mail: _____

Identification Number: _____ Social Security Number: _____

TO THE INDIVIDUAL: Please read the following and complete the information requested.

You have the right to request that we restrict our use or disclosure of your protected health information for treatment, payment or health care operations or with persons involved in your care or payment for your care. We are under no obligation to agree to your request. If we do, our agreement must be in writing. We will restrict our use or disclosure of your protected health information as you request. We may, notwithstanding our agreement, use or disclose the restricted information in case of a medical emergency, or when required or authorized by law.

You or TRIPLE-S SALUD may end a restriction agreement at any time by notifying the other in writing. If you agree with our decision to end the agreement, your protected health information will no longer be subject to the restriction. If you disagree, the restriction will not apply to your protected health information created or received after TRIPLE-S SALUD gave you its notice terminating the agreement.

SECTION B: Restriction requested.

Please specify the protected health information, the use or disclosure of which you want to restrict:

_____

_____

Please state the restriction you want to apply to that protected health information:

_____

_____

INDIVIDUAL'S SIGNATURE. YOU ARE ENTITLED TO A COPY OF THIS REQUEST

Signature: _____ Date: _____

If this request is by a personal representative on behalf of the individual, complete the following:

Personal Representative's Name: _____

Relationship to Individual: _____