STATE OF LOUISIANA
DIVISION OF ADMINISTRATION
OFFICE OF GROUP BENEFITS

REQUEST FOR RESTRICTION OF PROTECTED HEALTH INFORMATION

I hereby request a restriction to the Office of Group Benefits' uses and disclosures of my protected health information:

Health plan member/dependent name: _____

Date of Birth: _____

Address: _____

Telephone: _____
(primary number) *(alternate number)*

Member ID number: _____

What information do you want to be covered by a restriction?

_____

_____

_____

_____

_____

What uses and/or disclosures do you not want us to make?

_____

_____

_____

_____

_____

How long do you want the restriction to remain in effect? _____

Why do you want us to agree to this restriction?

_____

_____

_____

_____

_____

I understand that the Office of Group Benefits will review the request and that the restriction may be denied in the sole discretion of the Office of Group Benefits.

Signature of Health Plan Member/Dependent or Representative Date

Approved Denied (Circle One)

Expiration date of restriction (if any): _____

Signature of OGB Representative Date

Title