

Requests for Restrictions on the Use and Disclosure of Protected Health Information

Can you explain what this right is?

You have the right to request restrictions on the use and disclosures of Protected Health Information that we have about you.

Assurant Health is not required by federal law to agree to your request for restrictions on use and disclosure.

Assurant Health may terminate any approved restrictions if Assurant Health feels termination is appropriate. You also have the right to terminate any approved restrictions.

Your Costs:

There is no cost to you.

How To Make a Request:

Print and complete the form below. Don't forget to sign and date the form. Mail the completed form to: Assurant Health, PO Box 354, Milwaukee, WI 53201-0354.

Please do not include these instructions with your request.

A written response, indicating the approval or denial of your request, will be sent to the address you provide on the form.

Request for Restrictions on the Use and Disclosure of Protected Health Information



Complete and mail this form to:

Assurant Health, PO Box 354, Milwaukee, WI 53201-0354

Complete the following for the individual whose restriction is being requested:

Name _____

Policy No. _____

Street Address _____

Telephone No. () - _____

City/State _____

Social Security No. - - _____

ZIP Code _____

Birth Date / / _____

Assurant Health is required to provide you with the opportunity to request restrictions on the uses and disclosures of your protected health information. Assurant Health is not required to agree to your restriction request. Assurant Health is only required to attempt to accommodate reasonable requests when appropriate. Assurant Health reserves the right to terminate any approved restrictions if it feels that termination is appropriate. You also have the right to terminate any approved restrictions by sending a written termination notice to Assurant Health, PO Box 354, Milwaukee, WI 53201.

Please provide a full and specific description of the types of restrictions you are requesting regarding how and to whom your protected health information is used and disclosed. (You may use the back of this page to provide additional information, if necessary.)

We will notify you in writing regarding the approval or denial of your request. If your request is approved, we will provide you with the date your requested changes will be effective.

Pursuant to Federal law, I understand that Assurant Health may deny this request. By signing this form, I am confirming that it accurately reflects my wishes.

Signature of Requestor _____ Date _____

If signed by a Personal Representative:

Name of Personal Representative _____ Telephone Number () - _____

Relationship to individual or nature of authority _____

Signature of Personal Representative _____ Date _____

(If you are the Personal Representative, other than a parent or legal guardian, please attach a copy of any documents verifying your position as Personal Representative.)

(Please submit a separate request for each individual)