# Form FEP F15: Restriction Request

Use this form to exercise your right under federal privacy laws to request to restrict Blue Cross and Blue Shield of Vermont's (BCBSVT) and/or The Vermont Health Plan's (TVHP) use or disclosure of protected health information for treatment, payment or health care operations, or to persons involved in your care or payment for that care. This form is intended for BCBSVT Federal Employee Program (FEP) members.

**Section A: Member requesting restriction.**
Member Name: Date of Birth: _____

BCBSVT ID Number: _____

Address: _____

_____

Telephone: _____ E-Mail Address: _____

**Section B: Please read the following and complete the information requested**
You have the right to request that we restrict the way we use or disclose your protected health information for our treatment, payment, or health care operations or to persons involved in your care or payment for that care. We are under no obligation to agree to your request. If we agree, our agreement must be in writing. Notwithstanding our agreement, we may use or disclose the restricted information needed for your treatment in an appropriate medical emergency, or when the use or disclosure without your written permission is authorized or required by law.

You may end the restriction at any time by notifying us in writing. We may end our agreement to restrict use or disclosure of your protected health information at any time by notifying you in writing. If you agree with our decision to end the restriction, your protected health information will no longer be subject to the restriction. If you disagree, our termination of the restriction will apply only to your protected health information that we create or receive after we gave you our notice terminating the restriction. To exercise your right to request restriction on our use or disclosure of your protected health information, please provide the information requested below. Attach additional pages if necessary.

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:

_____

_____

**Section C: Individual's Signature**

I request that you restrict the use or disclosure of my protected health information as specified in Section B above. I understand that you are under no obligation to agree to my request and that there will be no agreement unless you inform me in writing that you agree to my request.

Signature: Date: _____

If you are a personal representative, such as a Legal Guardian or an agent acting under a Power of Attorney, you *may* be able to sign on behalf of the Member if the supporting documentation has the required language. This Form shall be accompanied by such supporting documentation for BCBSVT's Legal Department to determine whether authority is granted to authorize this Form.

Personal Representative's Name: _____

Relationship to Member or Authority to act as Personal Representative: _____

**Please keep a copy of this document for your records and send the completed Authorization via mail to Blue Cross and Blue Shield of Vermont, Attn: FEP Customer Service, PO Box 186, Montpelier, VT 05601-0186, fax to (802) 225-7700, or email FEPcustomerservice@bcbsvt.com.**