Request for Restriction or Termination of Restrictions

I hereby request the right to restrict the use and disclosure of my personal health information for payment and health plan operations. **I understand Avēsis may agree to this request as long as the restriction does not interfere with legitimate payment and health plan operation activity**. Avēsis will respond to this request within thirty (30) days with a written determination.

I understand that if the request for restriction is honored, Avēsis will document the request of the restriction and maintain it for a minimum of six (6) years. Avēsis shall abide by the request except in case of emergency. Avēsis may terminate this restriction if the individual agrees or requests the termination of the restriction or Avēsis informs the individual that it is terminating the restriction.

Member Information: (Individual whose information will be restricted)

Name: _____ Date of Birth: _____
(First, Middle, Last) (Month/Day/Year)

Address: _____
City State Zip Code

Telephone Number: _____
(including area code)

Employer Name: _____ Group Plan #: _____

Employee Name: _____

Please describe the information to be restricted:

_____

_____

Print Name: _____ Relationship: _____

Signature: _____ Date: _____

Note that no request for restriction or termination of restrictions will be processed unless you or your authorized representative have signed this form.

If you are an authorized representative (other than a parent of a minor child), you will need to provide documentation or an explanation of your authority to act for the member (e.g., Power of Attorney).

Request for Termination of Restrictions

I hereby request removal of the restrictions previously placed on my protected health information for payment and health plan operations. I understand that by terminating this restriction, my protected health information will continue to be used appropriately for payment and health plan operations in accordance with the Plan's privacy policies and procedures. Avēsis shall inform all necessary parties that it is terminating the restriction and will document and retain accordingly.

Name: _____ Date of Birth: _____
(First, Middle, Last) (Month/Day/Year)

Address: _____
City State Zip Code

Telephone Number: _____
(including area code)

Employer Name: _____ Group Plan #: _____

Employee Name: _____ Social Security Number: _____

Print Name: _____ Relationship: _____

Signature: _____ Date: _____

Note that no request for termination of restrictions will be processed unless you or your authorized representative have signed this form.

If you are an authorized representative (other than a parent of a minor child), you will need to provide documentation or an explanation of your authority to act for the member (e.g., Power of Attorney).

Please send this form to:

Avēsis, LLC.
Privacy Office
1295 W. Washington Street, Suite 212
Tempe, AZ 85281
privacyoffice@Avesis.com