Part I - Request for Restricted Use of Personal Health Plan Information

Form Received By _____ Date _____

Check One:

☐ Allied Pilots Association Voluntary Supplemental Medical & Custodial Care Benefit Plan (the "Plan")
☐ Allied Pilots Association Catastrophic Major Medical Benefit Plan (the "Plan")
☐ Allied Pilots Association Employee Health Benefit Plan (the "Plan")

You have the right to ask the Plan to restrict the use and disclosure of your health information for Treatment, Payment, or Health Care Operations, except for uses or disclosures required by law. You have the right to ask the Plan to restrict the use and disclosure of your health information to family members, close friends, or other persons you identify as being involved in your care or Payment for your care. You also have the right to ask the Plan to restrict use and disclosure of health information to notify those persons of your location, general condition, or death — or to coordinate those efforts with entities assisting in disaster relief efforts. If you want to exercise this right, your request to the Plan must be in writing.

The Plan is not required to agree to a requested restriction. And if the Plan does agree, a restriction may later be terminated by your written request, by agreement between you and the Plan (including an oral agreement), or unilaterally by the Plan for health information created or received after you're notified that the Plan has removed the restrictions. The Plan may also disdose health information about you if you need emergency Treatment, even if the Plan has agreed to a restriction.

1. Member or Employee Name:	1a. Member or Employee Number:
1b. Member or Employee Date of Birth:	1c. Your Name:
2. Name of Person Whose Records You Are Requesting:	2a. Relationship to Member or Employee: Employee ☐ Spouse ☐ Child ☐ Other ☐
3. Mailing Address:	3a. Your Relationship to Person in Box 2 Self ☐ Spouse ☐ Parent ☐ Child ☐ ☐ Other (please describe relationship):

Section A: Request to Restrict Use and Disclosure of Personal Heath Plan Information

I request that the use and disclosure of personal health plan information for the person in Box 2 be restricted in the manner described below:

_____

I understand that the Plan may deny this request. I also understand that the Plan may remove this restriction in the future if I am notified in advance.

Section B: Request to Terminate Restricted Use and Disclosure of Personal Heath Plan Information

☐ I request that the restriction on the use and disclosure of personal health plan information made on _____**[Date Initial Request Made]** be terminated. I understand that upon receipt of this form, the Plan will terminate the previously accepted restriction. Once a restriction has been terminated, the Plan will use and disclose personal health plan information as permitted or required by law.

☐ I agreed orally to terminate the restricted use and disclosure of personal health plan information belonging to the person in Box 2 made on _____**[Date Initial Request Made]**. This serves as formal documentation of that oral agreement.

Please return completed form to: HIPAA Privacy Official
Allied Pilots Association
14600 Trinity Blvd., Suite 500
Fort Worth, TX 76155
Fax 817-302-2146

Signature _____ Date _____

Part II - Determination of Request for Restricted Use of Personal Health Plan Information

Part II Prepared By _____ Date _____

After reviewing your request to restrict use of personal health plan information, the Plan has made the following determination:

☐ Request Approved ☐ Request Denied

Name of Plan Representative _____ Signature of Plan Representative _____ Date of Determination _____

Part III - Termination of a Request for Restricted Use of Personal Health Plan Information

Part III Prepared by _____ Date _____

The Plan is providing you with notice that it is terminating its agreement to restrict its use and disclosure of personal health plan information as documented above in Part II of this Form. Any personal health plan information created or received on or after _____will not be subject to the restriction. The Plan may use and disclose your personal health plan information as permitted by law.

Name of Plan Representative _____ Signature of Plan Representative _____ Date of Determination _____