TEAMCARE®
A CENTRAL STATES HEALTH PLAN

REQUEST TO RESTRICT USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

Participant's Identification Number or Social Security Number: _____

Participant's Name: _____

Your Name (if you are not the Participant): _____

Your relationship to the Participant (if you are not the Participant): _____

Describe the restriction you would like placed on your health information:

Effective date of your authorization: _____

Expiration date of your authorization: _____

Today's date: _____ Your signature: _____

Print Name: _____

TeamCare will make every attempt to comply with all reasonable requests for restrictions on the use and disclosure of your protected health information. If we are unable to comply your request, you will be notified.

Please mail the completed form to: Privacy Officer
TeamCare
PO Box 5125
Des Plaines IL 60017-5125

Or fax to: 847-518-9789