

# INDIVIDUAL REQUEST NOT TO USE OR DISCLOSE HEALTH INFORMATION

I understand that *American National Insurance Company* may use and disclose protected health information about me for purpose of health care treatment, payment and health care operations without my consent. I request to restrict use and disclosure of protected health information concerning health care treatment, payment or health care operations about me by *American National Insurance Company* in accordance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

## HEALTH PLAN NOT REQUIRED TO AGREE

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I understand that the company is not required to agree to this restriction.

## TERMINATION OF RESTRICTION

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I understand that if the company agrees to this restriction, either the company or I may terminate this restriction at any time. The termination of the restriction is only effective for future uses and disclosures.

## EMERGENCY TREATMENT EXCEPTION

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I understand that if protected health information must be used or disclosed to provide emergency treatment for me, then this restriction is void.

## QUESTIONNAIRE

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*Requestor:* Please complete all of the following questions. If the question is not applicable, please mark "N/A" on the answer line.

1. I request a restriction(s) of the information described in this request for the following reason(s):

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2. I request the following information be restricted (be specific):

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3. I request that use and disclosure of the above information be restricted in the following manner:

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4. I request that my protected health information not be disclosed to the following individuals or entities:

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I understand that if a restriction is not specifically listed above and agreed to in writing by the company, it will not be effective.

Please check all that apply:

**POLICY SERVICE**

Billing, coverage changes,  
addition/deletion of family members, etc.

**UNDERWRITING**

Medical records, applications, personal  
history telephone interviews, paramedical  
exams, reinstatements, etc.

**CLAIMS**

Medical records, provider billing,  
verification of benefits, etc.

This Date of  
Service Only: \_\_\_\_\_

This Doctor or  
Hospital Only: \_\_\_\_\_

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Signature of Requestor

Date