Group Insurance Trust of the
California Society of Certified Public Accountants
Request for Restriction on Use and Disclosure of Health Information

Please provide the information below. We cannot respond to your request without this information.

Your name: _____

Employee's name: _____ Employee's ID: _____

Best way to contact you: _____

This request applies to my following health information (describe the specific information or category of information):

_____

_____

Please apply the following restriction(s) on the use and/or disclosure of my health information:

_____

_____

Apply this request to the following Health Plans:

- ❑ CalCPA Health Medical Plans (PPO)
- ❑ CaliforniaCare Medical Plan (HMO)
- ❑ Vision Service Plan (Vision Plan)
- ❑ Managed Health Network (Mental Health)
- ❑ Delta Dental (Dental Plan)
- ❑ Other

Submission of this form does not guarantee that your request for restriction will be granted. Because the Health Plans use your health information as necessary for Health Plan administrative purposes, we may be unable to agree to your request. **The Health Plans are not required to accommodate to your request.** You will be notified that your request has been either granted or denied. Please note that, if we are able to grant your request, the Health Plans may use or disclose your health information in violation of the restriction if needed for your emergency treatment.

I hereby request the restriction described above. I understand that the Health Plans are not required to agree to my request. If the Health Plans do agree to my request, I understand that the restriction will take effect immediately, and will remain in effect until I revoke the restriction or until the Health Plans notify me that the restriction will be terminated. I understand that the Health Plans can terminate a restriction at any time. The restriction will not apply to my health information created or received after the restriction is terminated. I understand that my health information may be used or disclosed in violation of a granted restriction if necessary to provide me with emergency treatment.

_____ _____

Signature* Date

**If you are making this request on behalf of another individual, a completed Personal Representative Form must be on file with the Health Plans unless you are the individual's parent or guardian and you are also a participant in a Health Plan.*

Send this completed request form to:

Banyan Administrators, LLC
Managers for the CalCPA Health Programs
1215 Manor Drive, Suite 200
Mechanicsburg, PA 17055
Fax: (877) 237-4519

If you have questions about this form or your right to request to inspect or receive copies of your health information, contact Banyan Administrators, LLC at (877) 480-7923.

For internal use only:

- ❑ Approved Notice of extension sent:
- ❑ Denied Date received: Response Date:

Policy Attachment _____ 10452739