REQUEST FOR RESTRICTION OF INFORMATION
(To make information unavailable)

Date of Request: ____
(Month/Day/Year)

Member's Name: ____
First Middle Last

Member ID Number: ____

Member's Date of Birth: ____
(Month/Day/Year)

Member's Address:

____
Street Address

____

City State ZIP code

Requestor's Name (If different than member): ______________________________
First Middle Last

Requestor's Relationship to the Member: ______________________________
(Note: Written permission must be on file with Anthem so the information being requested can be released. If this permission is not on file, request a form to designate a Personal Representative and submit it to Anthem. This is not necessary for the parent of a minor child.)

Requestor's Phone Number: ______________________________

Please complete both sides of this form.

Please explain what information you would like restricted or made unavailable.

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Please list who you would like to restrict (make unavailable) your protected health information (PHI) from.
____

List the date you would like the restriction to begin: ____
(Month/Day/Year)

Would you like to have an end date (not required)? ____
(Month/Day/Year)

The start date will not be sooner than five business days of receipt of this request by Anthem.

Please explain the reason for the restriction.
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Please note this information will be reviewed, and this restriction may or may not be granted.

Name and signature of requestor or member:

____	__________________________________	__________
Print Name	Signature	Date

Enclosures: Get help in another language
Nondiscrimination notice

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