Request to Restrict the Release of Protected Health Information

A. Member Information

Member Name	Member Date of Birth	Member Identification Number (on membercard)

Street Address		

City	State	Zip

Phone Number	Alternate Phone Number
☐Landline ☐Cell Phone	☐Landline ☐Cell Phone

I request that EBMS revoke (cancel) the authorization that I have on file with EBMS, which permits the following person(s) or entity to access my personal and health information.

Person(s) / Entity restricted from accessing my information:

_____
_____
_____

B. Signature Required

I understand that signing and submitting this form restrict access to my PHI to the above listed individuals. I understand that this revocation will be effective five business days after EBMS receives it. This revocation will not be effective for information that EBMS discloses between the time that the Authorization is signed and when the revocation is received. I understand that redisclosure of any information released prior to this revocation may have already occurred or may occur in the future without my knowledge or consent; therefore, the privacy of my personal and health information may no longer be protected by law.

If signed by a person other than yourself, please check the relationship and provide proof of authority to do so:

☐Parent of a minor child
☐Power of attorney
☐Legal guardian
☐Personal representative of deceased member

Signature	Printed Name	Date

C. Finalize and Send

- Form must be fully completed
- Submit form via on of the following:
  - Scan and email to eligibility.general@ebms.com
  - Fax to: 406.652.5380
  - Mail to:
    EBMS
    P.O. Box 21367
    Billings, MT. 59104

This form satisfies all required elements of a valid authorization under the Health Insurance Portability and Accountability Act of 1996 (HIPAA)