Laborers Health and Welfare Trust Fund for Northern California
5672 Stoneridge Drive, Suite 100, Pleasanton, CA 94588 • Telephone: (707) 864-2800 • Toll Free: 1-(800) 244-4530

Request for Restriction of Protected Health Information (PHI)

Participant Name: _____ **Date of Birth:** _____

Address: _____ **Telephone:** _____

_____

Participant Social Security Number: _____

I hereby request that the following information not be used or disclosed by the Laborers Health and Welfare Trust Fund for Northern California, Health & Welfare Plans for Treatment, Payment, or Health Care Operations purposes:

I hereby request that the following information not be shared with the following individuals, who may be involved in my Treatment or in the Payment for my Treatment:

Please further explain this restriction. Please indicate why the restriction is necessary.

Expiration date of restriction: _____

Please indicate if the restriction should be sent to anyone to whom we may have disclosed information in the past. Please include the name and address of the organization or Individual.

Signed: _____ Date: _____
Signature of Participant