

**SOUTH CAROLINA BUDGET AND CONTROL BOARD
EMPLOYEE INSURANCE PROGRAM**

**REQUEST FOR RESTRICTION OF USE
OR DISCLOSURE OF PROTECTED
HEALTH INFORMATION**

INSTRUCTIONS:

Complete this form, or submit the information requested in any other written form to:

Director
Employee Insurance Program
1201 Main Street, Suite 300
P.O. Box 11661
Columbia, SC 29211

Please note that the Employee Insurance Program (EIP) is not required to agree to your request. An administrative fee may be charged for expenses incurred in implementing your restrictions of use or disclosure.

Name: _____ Benefits Identification Number: _____

Address: _____
(Street, P. O. Box)

(City, State, Zip Code)

Telephone Number: _____ Date: _____

Describe the Protected Health Information (PHI) for which you would like to have the use or disclosure restricted.

Indicate how you would like to restrict the use or disclosure of your PHI.

When may this restriction on use or disclosure be terminated?

Signature: _____