



Request for restrictions on use and/or disclosure of protected Health Information
NORTH DAKOTA PUBLIC EMPLOYEES RETIREMENT SYSTEM
SFN 58773 (Rev. 1-2022)

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PART A MEMBER INFORMATION

Name (Last, First, Middle)	NDPERS Member ID
Last Four Digits of Social Security Number	Date of Birth (mm/dd/yyyy)
Health Plan ID Number	

PART B MEMBER AUTHORIZATION & ACKNOWLEDGEMENT

Requester

I, as named above, am requesting a restriction on NDPERS use and/or disclosure of my health information (information that constitutes protected health information as defined in the Privacy Rule of the Administrative Simplification provisions of the Health Insurance Portability and Accountability Act of 1996) in the manner described below. I understand that NDPERS may deny this request for any reason. I also understand that if agreed to, NDPERS may not be able to honor this request if I require emergency treatment and that NDPERS may remove this restriction in the future, if I am notified in advance.

Description of Restriction of the Health Information to be Used or Disclosed. The following is a description of the specific health information I wish to restrict

Persons/Organizations Restricted from Use and/or Disclosure of Health Information. I request that the following person(s) and/or organization(s) not be allowed to use, receive and/or disclose the health information described above.

By signing this form, I am confirming that it accurately reflects my wishes.

Signature (Electronic Signature will not be accepted)

Date

If signed by personal representative

Print Name of Personal Representative

Relationship to participant or nature of authority

Signature of Personal Representative (Electronic Signature will not be accepted)

Date