

**REQUEST TO RESTRICT USE OR DISCLOSURE OF  
PROTECTED HEALTH INFORMATION (PHI)**

*HIPAA Privacy Policy Form – For PHI Related to MPC Benefit Plans*

**MEMBER NAME:** \_\_\_\_\_ **SSN OR EMPLOYEE ID:** \_\_\_\_\_

I, *(insert your name)* \_\_\_\_\_, request the following Marathon Petroleum benefits plans restrict the use or disclosure of my Protected Health Information (PHI) to carry out treatment, payment, or health care operations, **or** restrict disclosure of my PHI to family members, relatives, friends, or other persons identified by me who are involved in my care or payment for that care, in the manner described below.

- |  |   |  |
|--|---|--|
| <input type="checkbox"/> Health Plan   | <input type="checkbox"/> Retiree Health Plan        | <input type="checkbox"/> Employee Assistance Program             |
| <input type="checkbox"/> Dental Plan   | <input type="checkbox"/> Pre-65 Retiree Dental Plan | <input type="checkbox"/> Health Reimbursement Account Plan (HRA) |
| <input type="checkbox"/> Vision Plan   | <input type="checkbox"/> Pre-65 Retiree Vision Plan | <input type="checkbox"/> Exchange Health Reimbursement Account   |
| <input type="checkbox"/> Health Care Flexible Spending Account Plan (HCFSA) Plan | (EHRA)  |  |

*(check all Plans to which the restriction applies)*

**EXPLANATION OF RESTRICTION:**

Please be specific in your explanation. (i.e., discuss my health plan bill payments and eligibility issues only with me and not with my parents. or “do not release protected health information to my spouse”)

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

I understand that the MPC Plans are not required to accept my requested restrictions (except if it pertains solely to a health care item or service for which I, or someone on my behalf, has paid out-of-pocket in full). If the Plans do accept this request, the affected Plans agree to abide by the restrictions, except in emergency situations or where disclosure is required by law. I also understand that either I or MPC may terminate this restriction in writing at any time in the future.

In the event that I request information regarding my own benefits, such information may be released to me in writing (or by fax) in response to my written and signed request. In addition, I must provide a telephone number and Personal Identification Number/Word combination (up to six characters) that will serve as my unique identifier along with my Date of Birth so that I can discuss my Protected Health Information with a Benefits Service Center Representative by telephone.

**Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Printed Name:** \_\_\_\_\_ **Date of Birth:** \_\_\_\_\_

**Telephone Number:** \_\_\_\_\_ **PIN:\*** \_\_\_\_\_

*\*Your PIN should be a six character alpha/numeric combination that is known only to you and that you can remember easily.*

**HIPAA PRIVACY OFFICER COMMENTS:**

- Accept this request.  
 Reject this request. Reason: \_\_\_\_\_  
 Dependent contacted.

**Return completed form to:  
MPC Benefits  
Attn: HIPAA Privacy Officer  
539 South Main Street  
Findlay, OH 45840  
privacy@marathonpetroleum.com**