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 that the following Plans of Marathon Petroleum Company LP (MPC) 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.

___ Health Plan ___ Wellness Plan

___ Retiree Health Plan ___ Employee Assistance Program

___ Dental Plans ___ Health Care Flexible Spending Account

___ Vision Plans ___ Health Reimbursement Accounts

(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.

PRIVACY OFFICER COMMENTS:

___ Accept this request.

___ Reject this request. Reason: _____

___ Dependent contacted.

Return form to HIPAA Privacy Officer, 539 S. Main Street, Findlay, OH 45840.