American Specialty Health

REQUEST TO WITHDRAW CONSENT FOR CONSUMER HEALTH DATA

Please read this form carefully. Failure to fully complete all applicable sections of the form may result in the form being returned to you. Responses should be printed in spaces provided using blue or black ink.

RETURN THIS FORM TO:
Attn: Privacy Officer
American Specialty Health
10221 Wateridge Circle, San Diego, CA 92121
Tel: 1-877-427-4766; **Fax:** 1-877-414-2746 **Email:** HIPAA@ashn.com

Instructions for completion of this Form:

- **Member Information section** – provide all requested information.
- **Request Details section** – choose from the items available and/or write in information.
- **Acknowledgement & Signature section** – please sign, print your name, and date this form. If this request is being made by someone other than the member, you must complete the information below the Signature line, describe your authority to make this request on the member's behalf, and include copies of the supporting documentation.

MEMBER INFORMATION

Member Name:
Date of Birth:
Street Address[i]:
City:
State:
Zip:
Telephone:
Email[i]:

REQUEST DETAILS

☐ I hereby request American Specialty Health to withdraw consent of my consumer health data absent reasonable exceptions involving the following products (select all that apply):

☐ Active&Fit Direct

☐ Active&Fit (Active&Fit Enterprise)

American Specialty Health

☐ Active&Fit Now

☐ ChooseHealthy

☐ Other (specify _____)

☐ I hereby request American Specialty Health to withdraw consent for future collection and processing of my consumer health data:

Please note: some products offered by American Specialty Health are not subject to privacy laws pertaining to consumer health data because they are governed by the Health Insurance Portability and Accountability Act of 1996 (Public Law 104-191), the Health Information Technology for Economic and Clinical Health Act (Public Law 111-5), or Gramm-Leach-Bliley Act (Public Law 106-102). For these products, rights under the applicable Consumer Health Data laws may not apply.

ACKNOWLEDGEMENT & SIGNATURE

In signing this form, I understand that:

- American Specialty Health (ASH) will respond within 45 days of receiving this request. I also understand that ASH will contact me to verify this request.
- If ASH approves this request, ASH will cease future collection and processing of your consumer health data, de-identify your consumer health data, or aggregate your personal information, in whole or in part, and inform you when the change is completed.
- Should ASH determine it is not able to make the deletion, ASH will respond in writing as to why.

Signature _____ Date of Signature_____
Printed Name_____

Relationship to Member: ☐ Self ☐ Other (complete the information below)

If this request is being made by an individual other than the member, please complete the information below, describe your authority to make this request on the member's behalf and include copies of supporting documentation.

Name_____
Street Address_____
City_____State_____ZIP _____
Telephone_____

Description of Representative's Authority to Act/Relationship to Member (choose one):

☐ Member is a minor and I am the member's parent or legal guardian.

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☐ Member is deceased and I am the member's surviving spouse or next of kin, the executor/administrator of the member's estate, hold durable power of attorney, or I am otherwise legally authorized to act on behalf of a deceased member or the member's estate (please attach necessary documentation).

☐ I am the member's agent, as designated in the member's Durable Power (please attach necessary documentation).

☐ Other (please describe and attach necessary documentation):_____

REQUEST TO DELETE CONSUMER HEALTH DATA CONTINUED.

[i] This information will be used to respond to your request. If different than the information linked to your account, please specify.