[Your Name]
[Your Address]
[City, State, Zip Code]
[Your Phone Number]
[Your Email Address]

[Date]

[Health Insurance Company Name]
[Privacy Officer or Privacy Department]
[Address]
[City, State, Zip Code]

RE: Request to Opt-Out of Third-Party Disclosures
Member Name: [Your Full Name]
Policy/Member ID Number: [Your ID Number]
Group Number: [Your Group Number]

To Whom It May Concern,

I am writing to formally request that you restrict the disclosure of my Protected Health Information (PHI) and personal data to third parties for marketing, research, or any other purposes not directly related to my treatment, payment of claims, or essential healthcare operations.

In accordance with HIPAA and applicable privacy laws, please record the following preferences for my account:

- I opt-out of the sharing of my personal information with third-party affiliates for marketing purposes.
- I opt-out of the sale of my personal data to any third-party entities.
- I request that my medical information not be shared with data brokers or research organizations without my explicit written consent for each specific instance.

Please confirm in writing that this request has been received and that my privacy preferences have been updated in your system. This opt-out request should remain in effect until I provide written notice otherwise.

Thank you for your prompt attention to this matter.

Sincerely,

[Signature]

[Your Printed Name]