GO EAST MEDICAL SERVICES
行 健 醫 療 中 心

GEMS#:

NAME:

Date of Birth:

REQUEST FOR A RESTRICTION ON USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION (PHI)

Request approval by Privacy Officer before effective: Please provide phone number for Privacy Officer to contact you if we cannot comply with the request. Request will be implemented of the date received by the Privacy Officer.

Date of Request: _____/_____/_____

Name: _____ **Phone Number:** _____

Address: _____ **Email Address:** _____

City: _____ **State:** _____ **Zip Code:** _____

GEMS may use and disclose your protected health information for treatment, payment and health care operations. GEMS may also disclose to those involved in your care (family member, close relative, friend, etc.) information directly relevant to their involvement with your care, or payment for such care, or to notify them of your location, general condition, or death.

To request a restriction, please fill out this form.

I request that GEMS:

☐ **Restrict the use and disclosure of my information for the following treatment, payment, and health care operations purposes:**

_____

_____

☐ **Restrict the use and disclosure of my information to the following person or entity (provide name of person or entity and relationship):**

_____

_____

☐ ***I request to terminate a prior request for restriction dated:***

_____

By completing this form and signing below, I understand that:

- The completion of this form does not mean your request has been accepted. The request will be reviewed by the Privacy Officer, who will inform you if your request has been rejected.
- Even if your request for restriction is accepted, we may use your information if needed to provide you with emergency treatment or in certain limited circumstances.
- We must agree to your request to restrict disclosure of your PHI to a health plan if the disclosure is to carry out payment or health care operations and is not otherwise required by law; and the PHI

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pertains solely to a health care item or service that you, or someone other than the health plan on your behalf, has paid in full.

- We have the right to terminate this restriction by informing you of the termination in writing; the termination will only apply to information created or received after we have informed you of the termination.
- You have the right to terminate this restriction by making a written request to terminate.

Signature of Patient or Legal Representative	Date
Name of Legal Representative	Relationship of Legal Representative
Signature of Witness (Required if patient is unable to sign)	Date

Office Use Only: Verify the identity of individual to ensure that the requester has the authority to request this restriction.

Type of ID submitted	Staff name verifying the identity	Date	Request Response ☐ Approve ☐ Deny

Date	Received from patient	Forwarded to Privacy Officer	Answer received from Privacy Officer	Answer given to patient