GEMS#:

NAME:

Date of Birth:

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

限制使用或透露受保護醫療資料 (PHI) 申請

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.
在申請生效前獲取隱私保密監察專員批准：請提供電話號碼，以便隱私保密監察專員在無法批准您的申請時與您聯繫。 申請將於隱私保密監察專員收到之日起生效。

Date of Request: ______ / ______ / ______
申請日期：

Name: **姓名：** ____________		Phone Number: 電話號碼：____________	
Address: **地址：** ____________		Email Address: **電郵地址：** ____________	
City: **城市：** ____________		State: **州：** ______	Zip Code: **郵政編碼：** ______

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.
行健醫療中心 (GEMS) 可能會使用和透露您的受保護醫療資料 (PHI) 以進行治療、付款和醫療運營。行健醫療中心 (GEMS) 也可能向參與您護理的人員（家庭成員、近親、朋友等）透露與他們參與您的護理或此類護理費用相關的信息，或通知他們您的位置、一般狀況或死亡。

To request a restriction, please fill out this form.
想要請求限制，請填寫此表格。

I request that GEMS:
本人希望限制行健醫療中心 (GEMS)：

☐ Restrict the use and disclosure of my information for the following treatment, payment, and health care operations purposes:
限制出於以下治療、付款和醫療運營的目的使用和透露我的資料：

____

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)

限制使用或透露受保護醫療資料 (PHI) 申請

☐ Restrict the use and disclosure of my information to the following person or entity (provide name of person or entity and relationship):
限制以下個人或機構使用和透露我的資料（提供個人或機構的名稱以及關係）：

____

____

☐ *I request to terminate a prior request for restriction dated:*
我請求終止先前於此日期提交的限制申請：

____

By completing this form and signing below, I understand that:
通過填寫此表格並在下方簽署，本人明白：

- 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.
  填寫此表格並不代表您的申請已被批准。 隱私保密監察專員將審核您的申請，並將在無法批准您的申請時通知您。

- 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.
  即使您的限制申請被批准，我們也可能在需要為您提供緊急治療或某些有限的情況下使用您的資料。

- 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 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.
  如果透露的目的是為了進行付款或醫療運營且法律沒有其它規定，我們必須批准您的申請，限制與醫療保健計劃透露您的 PHI； 並且 PHI 僅涉及您或代表您的其他人（醫療保健計劃除外）已全額支付的醫療護理項目或服務。

GEMS#:

NAME:

Date of Birth:

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

限制使用或透露受保護醫療資料 (PHI) 申請

- 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.
  我們有權以書面形式通知您以終止此限制； 並且該終止僅對我們通知您終止後所創建或接收的資料有效。
- You have the right to terminate this restriction by making a written request to terminate.
  您有權通過書面形式請求終止此限制。

Signature of Patient or Legal Representative 病人或合法代表簽名	Date 日期
Name of Legal Representative 合法代表姓名	Relationship of Legal Representative 合法代表與病人的關係
Signature of Witness (Required if patient is unable to sign) 見證人簽名（病人無法自行簽字時此項必填）	Date 日期

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

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