0I

REQUEST FOR RESTRICTION

Use this form to request that GEHA restrict the uses or disclosures of your protected health information ("PHI").

About you, the GEHA member whose PHI is to be restricted

Plan ID Number: _____

Member Name: _____ **Date of Birth:** _____

Address: _____

Telephone Number: _____

Please place a check mark in front of each plan you want this Access request to be applied:

___ GEHA Health Plan

___ GEHA Connection Dental Federal Plan

___ Connection Dental *Plus* Plan

___ CONNECTION Vision Plan

Restriction Information

Do not release information specified below to: _____

_____

Information: _____

Reason: _____

Signature and Acknowledgement

- I understand that any request GEHA accepts will be limited to information under GEHA's control, and the request will be communicated to GEHA's Business Associates.
- I understand GEHA is not required to accept my restriction request.
- In some cases, GEHA has the right to terminate agreed upon restrictions. If it does so, GEHA will inform you of the termination in writing. Any such termination will only apply to information created or received after we have informed you of the termination.
- I have the right to request GEHA terminate the restriction understanding the termination will apply to information created or received after the date of termination, by contacting the Privacy Office at the address below.

Date: _____

Patient or Legal Representative Signature: _____

Relationship to patient: _____
(i.e. parent, legal guardian, power of attorney, etc.)

NOTE: If the signature is not that of the patient or the parent when the child is a minor, appropriate legal documentation is required to accept the signature.

PLEASE RETAIN A COPY FOR YOUR RECORDS AND RETURN THE ORIGINAL SIGNED FORM TO:

ATTN: Restriction Request
GEHA
P.O. Box 21542
Eagan, MN 55121
FAX: 816-257-3283