GEHA

0I

REQUEST FOR RESTRICTION

This form is for subscribers and members covered by the GEHA Health, GEHA Connection Dental Federal, CONNECTION Dental *Plus* plans and/or Connection Vision Plan. Please place a check mark in front of each plan you want this Restriction request to be applied.

NOTE: At least one line MUST be checked for this form to be valid.

- ☐ GEHA Health Plan (includes Connection Vision Plan)
- ☐ GEHA Connection Dental Federal Plan (includes Connection Vision Plan)
- ☐ CONNECTION Dental *Plus* Plan (includes Connection Vision Plan)
- ☐ CONNECTION Vision Plan only

You have the right to request that your protected health information will not be disclosed to a specific person. You may also request that your protected health information will not be used or disclosed for purposes of treatment, payment or health care operations (see the "Notice of Privacy Practices"). Please note: GEHA is not required to accept a restriction.

NOTE: ALL AREAS OF THIS FORM MUST BE COMPLETED IN FULL. INCOMPLETE FORMS WILL BE CONSIDERED INVALID AND RETURNED.

Subscriber/Member Information:

Subscriber Name: _____

Address: _____

Subscriber ID Number: _____ **Telephone Number:** _____

Patient Name: _____ **Date of Birth:** _____

I request restriction of my protected health information from the following person (complete additional form if more than one person). I understand that if I later sign an authorization conflicting with this restriction, the restriction will be ignored.

Name: _____ **Phone Number:** _____

Address: _____

Relationship to You: _____

Full Description of the Reason for this Request (continue on back if additional space is required):

_____

_____

_____

_____

I understand that, if a restriction is accepted, GEHA may revoke such agreement to a restriction, if 1) I agree to or request the revocation of the restriction(s) in writing, in which case GEHA may disclose all of my protected health information; 2) I orally agree to the revocation and the oral agreement is documented, followed by written notice, in which case GEHA may disclose all of my protected health information; or 3) I am informed by GEHA that GEHA is terminating the agreement to a restriction without my agreement, in which case the revocation is only effective with respect to protected health information created or received after I have been informed by GEHA. I understand that my revocation of this restriction will not affect any action that GEHA has taken based upon this restriction before GEHA actually receives my request to revoke it.

By signing this form, I am requesting a restriction of my protected health information disclosure to the above noted person(s) and understand that GEHA is NOT required to accept the requested restrictions. If accepted, GEHA and its representatives agree not to release my protected health information to the person(s) specified. I further **understand that this will require up to fifteen (15) working days from the date received by GEHA to execute this request and forward to GEHA's business associates, who partner with us to assist in providing services in areas such as pharmacy, radiology, precertification, vision, etc.** (as outlined in GEHA's Notice of Privacy Practices available at www.geha.com). If denied, I understand protected health information will be disclosed as specified in GEHA's Notice of Privacy Practices. I understand I will be notified by mail as to the determination. **PLEASE NOTE: IF the restriction is ACCEPTED, it will be valid even if you should terminate GEHA coverage. If you would then re-enroll at any time, an accepted restriction would continue to remain valid unless you would revoke it in writing after re-enrollment.**

Date: _____

Patient or Legal Representative Signature: _____

Relationship to patient: (i.e. parent, legal guardian, medical 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.

If the restriction(s) is ACCEPTED by GEHA, I request correspondence be sent to the following address and telephone calls directed to the following number:

Name: _____ **C/O (in care of):** _____

Address: _____ **Telephone Number:** _____

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

GEHA
ATTN: Restriction Request
P.O. Box 438
Independence, MO 64051-0438
FAX: 816-257-3283