



**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.

08/05/2019

**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**

PHI12/R11  
ENR-1710-PHI12  
GE-FRM-0119-002