



# Women Gynecology & Childbirth Associates, P.C.

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## **Restriction of Use or Disclosure of Protected Health Information (PHI) Policy**

You have the right to REQUEST that the use and disclosure of your protected health information (PHI) be restricted for treatment, payment, and health care operations, as well as restricting disclosure to only certain people, such as certain family members only. If a guarantor other than yourself is listed as person responsible for payment, they may receive treatment/diagnostic information for billing purposes.

The restriction request must be in writing, be specific as to what information is covered by the request, whether it covers use, disclosure, or both, and to whom those limitations apply.

WGCA does not have to agree to your request.

If WGCA agrees to the request, it will honor the request except when overriding laws or emergencies apply.

I authorize WGCA to discuss my PHI with the following person(s) or entity(ies):

<u>Name</u>	<u>Relationship</u>	<u>Describe any restrictions regarding the sharing of information</u>
_____	_____	_____
_____	_____	_____

### **Patient Contact Information:**

	<u>Telephone Number</u>	<u>Can WGCA leave a message?</u>		<u>Comments/Restrictions:</u>
		<u>Yes</u>	<u>No</u>	
Home	# _____	<input type="checkbox"/>	<input type="checkbox"/>	_____
Cell Phone	# _____	<input type="checkbox"/>	<input type="checkbox"/>	_____
Work	# _____	<input type="checkbox"/>	<input type="checkbox"/>	_____
E-mail	_____			_____
Emergency contact	Name: _____	Relationship: _____	<input type="checkbox"/>	<input type="checkbox"/>
	Telephone: _____	_____		
Other	Name: _____	Relationship: _____	<input type="checkbox"/>	<input type="checkbox"/>
	Telephone: _____	_____		

### **I have been offered a Notice of Privacy Practices from WGCA.**

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Print Name

\_\_\_\_\_  
Date of Birth

\_\_\_\_\_  
Witness if applicable

\_\_\_\_\_  
Date

\_\_\_\_\_  
Witness print name / relationship