First MEDICAL HEALTH PLAN, INC.

REQUEST FORM FOR RESTRICTION OF USE AND/OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

You have the right to request restrictions on certain uses and disclosures of your Protected Health Information in compliance with Section 164.522 of the Privacy Rule. First Medical is not obligated to accept the restrictions you request if they affect your medical care or are not aligned with First Medical's compliance with certain laws and regulations.

You may submit your request by addressed to the **Chief Compliance and Privacy Officer of First Medical Health Plan, Inc.,** at **PO Box 191580, San Juan, PR 00919-1580**, by email at: cumplimiento@firstmedicalpr.com, by fax 787-300-3913 or by delivering it directly to any of First Medical Health Plan, Inc.'s Service Offices.

I. Beneficiary/Subscriber Information:		
Name:	Middle name:	Last Name:
Date of Birth (*Month/Day/Year*):		Plan Identification Number/Contract Number:
Address:		
Primary Phone:		Alternate Phone:
Email:_____		
☐ I authorized First Medical to send information to my email in a secure (*Encrypted*) manner.		

II. Type of Application
☐ **New Request -** Restriction of Use and/or Disclosure of Protected Health Information
☐ **Revoke Restriction on Use and/or Disclosure -** Request the revocation of the restriction of use and/or disclosure of Protected Health Information. Please indicate the effective date of revocation. _____*

III. Restriction on Use and/or Disclosure of Protected Health Information:
I understand that a disclosure of Protected Health Information may be necessary in the event of an emergency, treatment, payment, health care operations, or when required or authorized by law.
Please specify what protected health information you wish to limit from being used or disclosed:
_____
_____
_____

IV. Duration		
This restriction of use and/or disclosure is effective from the date of the request until the duration you specify:		
☐ One (1) year	☐ Other Term ____/____/_____	☐ Does not expire

V. Signature	
Beneficiary/Subscriber Signature:	Date:
If you are a Legal Representative of the Beneficiary/Subscriber, you must: 1. Indicate your full name: _____ 2. Describe your authority to act for the Beneficiary/Subscriber (e.g., power of attorney, court order, or medical certification) _____	

3. Provide a copy of the legal document that appoints you as Legal Representative. A Social Security proxy document is not admissible for purposes of this form (please request assistance from a Customer Service Representative).

Signature of the Legal Representative: _____Date: _____

For Exclusive Use of FMHP Only Compliance Department-Privacy Unit

☐ Application Accepted
☐ Application Denied Reason: _____
☐ Beneficiary/Subscriber Notified Date: _____

If you need additional information, please contact First Medical Health Plan, Inc.'s Privacy Unit at 787-474-3999, extension 2108/2583. We are available Monday through Friday from 8:00 a.m. to 5:00 p.m.

The Customer Service Department offers free language interpreter services and sign language. This includes services in alternate formats such as Braille, large print, and translation to other languages, verbally or written, among others. If you need plan information in another format or language, please contact our Customer Service Department at the number on the back of your plan card.

El Departamento de Servicio al Cliente ofrece servicios de intérprete de idiomas y lenguaje de señas libre de costo. Esto incluye, servicio de formatos alternos tales como: Braille, letra agrandada y traducción a otros idiomas, verbal o escrito, entre otros. Si usted necesita información del plan en otro formato o lenguaje, por favor comuníquese con nuestro Departamento de Servicio al Cliente al número que aparece al dorso de su tarjeta del plan.

First Medical *cumple con las leyes federales aplicables de derechos civiles y no discrimina en base a raza, color, origen de nacionalidad, edad, discapacidad, o sexo*. **First Medical** *complies with applicable federal civil rights laws and does not discriminate based on race, color, national origin, age, disability, or sex.*

First Medical *遵守適用的聯邦民權法律規定，不因種族、膚色、民族血統、年齡、殘障或性別而歧視任何人*