Request for Restriction and/or Confidential Communications

The undersigned patient or patient's personal representative hereby requests:

- ☐ Restriction of use and disclosure of protected health information;
- ☐ Removal of restriction of use and disclosure of protected health information; or
- ☐ Confidential communications

Patient Name _____Date of Birth_____

Address _____

City/State/Zip_____

Telephone _____ Fax Number _____
(Include area code) *(Include area code)*

Effective Date _____

RESTRICTION/REMOVAL OF RESTRICTION

Gerald Champion Regional Medical Center ("GCRMC") is not required to agree to requests for restrictions, however, we will consider all reasonable requests.

Describe the request for a restriction or for removal of a restriction:

_____

Name of Patient or Personal Representative *(PLEASE PRINT)*_____

Signature of Patient or Personal Representative _____ Date _____
(If Personal Representative, include a description of authority to act for patient)

CONFIDENTIAL COMMUNICATIONS

Alternate Address _____

Alternate City/State/Zip _____

Alternate City/State/Zip _____

Name of Patient or Personal Representative *(PLEASE PRINT)*_____

Signature of Patient or Personal Representative _____Date _____
(If Personal Representative, include a description of authority to act for patient)

Return this completed form to:
Privacy Officer - Gerald Champion Regional Medical Center
2669 North Scenic Drive Alamogordo, NM 88310
If you have any questions, please contact the Privacy Officer directly at 575-443-7857

For GCRMC Use Only: Date that this request was received by GCRMC _____

Request Disposition: _____ Approved _____ Denied Date Action Taken _____

Gerald Champion Regional Medical Center
The Evolution of Excellence