PLUMAS COUNTY, CALIFORNIA

TERMINATION OF SPECIAL RESTRICTION REQUESTS

Date:_____

Name:_____

Date of Birth:_____

The patient named above requested a special restriction on the use or disclosure of protected health information on ____/____/____.

☐ The patient hereby requests that the special restriction be terminated.

☐ The patient hereby agrees to the termination of the special restriction.

Signature of patient or representative:_____

If representative, give relationship to patient:_____

☐ The patient orally agrees to the termination.

Signature and title of staff member witnessing the oral agreement:

☐ _____ is hereby informing you that the agreement is terminated. The termination is effective only with respect to PHI created or received by us after you have received this notification.

Signature and title of department representative