Termination of Restriction Form

Date: _____ Date of Birth: _____

Member Name: _____ Member CIN: _____

The member named above requested a restriction on the Use and Disclosure of Protected Health Information (PHI) dated [DATE].

☐ The member requests the restriction to be terminated

Member Signature: _____

If Authorized Representative (please include legal documentation):

Print Name: _____ Relationship to Member: _____

☐ The member agrees to the termination of the restriction.

Member Signature: _____

If Authorized Representative (please include legal documentation):

Print Name: _____ Relationship to Member: _____

☐ The member agreed orally to the termination.

Signature of CalOptima Representative who received the oral agreement:

_____

☐ CalOptima is informing you that the agreement is terminated. The termination is effective only with respect to Protected Health Information (PHI) created or received by us after you received this notification.

To learn more about your privacy rights, please refer to your copy of the CalOptima Notice of Privacy Practices. It can also be found on our website at www.caloptima.org or by calling CalOptima's Customer Service Department at **1-714-246-8500** or toll-free at **1-888-587-8088**. We are available Monday through Friday from 8 a.m. to 5:30 p.m. Members with hearing or speech impairments can call our TDD/TTY line at **1-714-246-8523** or toll-free at **1-800-735-2929**. We have staff who speak your language.

If you believe your privacy rights have been violated, you may file a complaint with CalOptima by calling **1-714-246-8500** or write to:

CalOptima
Customer Service Department
505 City Parkway West
Orange, CA 92868

CalOptima cannot take away your health care benefits or do anything to hurt you in any way if you choose to file a complaint or use any of your privacy rights.

Sincerely,

HIPAA Privacy
Office of Compliance