Termination of Restrictions on Use and Disclosures

I, _____, formally terminate the previous restriction on the use and disclosure of my protected health information and understand the termination of the restriction is only effective for future uses and disclosures.

Description of Restriction Terminating:

Your Name (printed):	Your Contact Information (Address, Phone, Email):
Your Signature:	Date:

If a legal representative signs on behalf of the individual, a copy of the legal representative's authority must be attached to this form, e.g. Health Care Power of Attorney, Executor/Administrator of an estate.

TO BE COMPLETED BY HEALTHTRUST WORKFORCE MEMBER	
Name of HealthTrust Workforce Member Receiving Form:	Date:

TO BE COMPLETED BY THE HEALTHTRUST PRIVACY OFFICER

HealthTrust is no longer required to restrict use and disclosure per the previous restrictions as of the date entered by the HealthTrust Privacy Officer below.

Privacy Officer (printed):	Date of Original Restriction:
Privacy Officer Signature:	Date Termination Effective (receipt of this form):

The HealthTrust Privacy Officer has contacted the following Departments regarding this termination:

☐ Enrollee Services ☐ Benefits and Wellness ☐ Benefits and Coverage ☐ Human Resources ☐ Other: _____

Additional Comments:
