

## **TERMINATION OF RESTRICTION FORM**

Date:	Date of Birth:
Member Name:	Member CIN:
The member named above red Health Information (PHI) date	
	(mm/dd/yyyy)
☐ The member requests th	e restriction to be terminated.
Member Signature:	
If Authorized Representative (pl	ease include legal documentation):
Print Name:	Relationship to Member:
☐ The member requests th	e restriction to be terminated.
Member Signature:	
If Authorized Representative (pl	ease include legal documentation):
Print Name:	Relationship to Member:
☐ CalOptima Health is info	rming you that the agreement is terminated.
The termination is effective only received by us after you received	with respect to Protected Health Information (PHI) created of this notification.
☐ The member agreed ora	ly to the termination.
Print Name and Signature of Cal	Optima Health Representative who received the oral agreement
Print Member Name	Member Sianature



For more information about your privacy rights, please refer to your copy of the CalOptima Health Notice of Privacy Practices. A copy can be found on our website: www.caloptima.org, or from CalOptima Health's Customer Service Department by calling **1-714-246-8500** or toll-free at **1-888-587-8088**, Monday through Friday from 8 a.m. to 5:30 p.m. Members with hearing or speech impairments can call our TDD/TTY 711. We have staff who can speak your language.

If you believe your privacy rights have been violated, you may file a complaint with CalOptima Health or with the secretary of the Department of Health and Human Services.

To file a complaint with CalOptima Health, contact CalOptima Health Customer Service Department at **1-714-246-8500** or write to:

**ATTN: Customer Service Department CalOptima Health** 

505 City Parkway West Orange CA 92868

CalOptima Health 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 the privacy rights in this Notice.

Sincerely,

Privacy Officer