

Request for Restriction Termination

I hereby request termination of the restrictions previously placed on my protected health information for treatment, payment and health plan operations.

Please describe the restriction(s) you want terminated:

Please print the following information:

Member name: _____ Date of birth: _____

Member ID: _____ Daytime phone: _____

Address: _____

Alternative phone: _____

Member signature: _____ Date: _____

Legal representative signature: _____ Date: _____
(*only if member is unable to sign)

Relationship to member: _____

Please note: If you are a legal representative for the member, you must attach copies of your authorization as required by state law to represent the member (e.g., healthcare power of attorney, healthcare surrogate, living will, or guardianship papers).

To prevent a delay in fulfilling your request, please verify all fields on this form are complete and accurate. If information is missing, we will return the form to you for completion. Please attach a separate sheet if you need more space.

Please send this form to:
Privacy Office
P.O. Box 1438
Louisville, KY 40202-1438

CarePlus will follow the more stringent of all federal and state laws and regulations.

TerminateRestrictions 4/08

For CarePlus Use Only

FLHJEC5EN 0721



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Español (Spanish): Esta información está disponible de forma gratuita en otros idiomas. Favor de llamar a Servicios para Afiliados al número que aparece anteriormente.

Kreyòl Ayisyen (French Creole): Enfòmasyon sa a disponib gratis nan lòt lang. Tanpri rele nimewo Sèvis pou Manm nou yo ki nan lis anwo an.

