# COUNTY OF ORANGE, CA   HEALTH CARE AGENCY
# TERMINATION OF SPECIAL RESTRICTION

Photocopy/Facsimile may be used as an original

**CLIENT/PATIENT INFORMATION:**

NAME: _____
        *Last*                    *First*                    *MI*

AKA: _____

SOC. SEC.#: ____ **-** ____ **-** _____   DATE OF BIRTH _____

Return this completed form for processing to the Custodian of Records office:
200 W. Santa Ana Blvd, Suite 125, P.O. Box 355, Santa Ana, CA  92702, Phone (714) 834-3536, Fax (714) 835-9312

---

The patient name above requested a special restriction on the use or disclosure of protected health information on _____ (date).

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

   Signature of patient or representative: _____

   If representative, give relationship: _____

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

   Signature of patient or representative: _____

   If representative, give relationship: _____

☐ The patient orally agreed to the termination of the special restriction.

   Signature of Health Care Agency agent who witnessed the oral agreement: _____

☐ The Health Care Agency 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 of Health Care Agency representative _____ :

---

For more information about your privacy rights, see the "Notice of Privacy Practices" available on our website at http://www.ocgov.com/hipaa/forms.htm  or by sending a written request to the address shown above.

If you believe your privacy rights have been violated, you may file a complaint with the County of Orange or with the Secretary of the Department of Health and Human Services.  To file a complaint with County of Orange, contact the HIPAA Privacy Officer at (714)834-5172 or visit our website.  All complaints must be submitted in writing.  **You will not be penalized for filing a complaint**.

---

**TODAY'S DATE:** _____   **SIGNATURE:** _____

**PRINTED NAME:** _____

**RELATIONSHIP:** *Choose One***:** ☐ Client/Patient  ☐ Parent  ☐ Guardian  ☐ Representative  ☐ Conservator  ☐ Other: _____

**COMPLETE ADDRESS:** _____   **TELEPHONE #** _____
    *Street Address*                    *City*        *State*      *Zip Code*

F042-01.2010 (REV 01-10)          Distribution: **Original** - Releaser of Records   **Copy** - HCA Chart   **Copy** - Client/Patient