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) being terminated:

_____

_____

_____

_____

_____

_____

_____

_____

Please print the following information:

Name: _____ Date of Birth: _____

Daytime Phone: _____

Alternate Phone: _____

Address: _____

_____

_____

Signature: _____ Date: _____

Signature of Legal Representative

Only if individual is incompetent*: _____ Date: _____

If signed by Legal Representative, relationship to individual: _____

***If signed by Legal Representative, must provide representative documentation as required by state law, i.e., Health Care Power of Attorney, Health Care Surrogate, Living Will or Guardianship papers.**

To prevent a delay in fulfilling your request, please verify that all fields on the form are accurately completed. If information is missing, the form will be returned to you for completion.

Please attach a separate sheet if additional space is needed.

Please send this form to:
Harris, Rothenberg International, Inc. dba Humana EAP and Work Life Services,
100 William St., 10th Floor
New York, NY 10038

This organization follows the more stringent of all federal and state laws and regulations.