EAST CAROLINA UNIVERSITY
Health Care Components
PATIENT REQUEST FOR TERMINATION OF PREVIOUSLY APPROVED RESTRICTIONS ON THE USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

NOTICE TO PATIENT: Your request for termination of restrictions to your protected health information (PHI) is **only** applicable to your PHI in a designated record set maintained by

_____
(Print Name of ECU Health Care Component)

If you would like to terminate a restriction to your PHI in a designated record set maintained by any other Health Care Component of East Carolina University, a separate request must be submitted for that area.

I understand that:

1. There are legal restrictions on the manner in which the East Carolina University's (ECU) Health Care Components may use or disclose protected health information (PHI) about me.
2. I have the right to request additional restrictions on the uses or disclosures of my health information in certain situations, in addition to the restrictions already imposed by law.
3. ECU is not required to grant my request for additional restrictions except as noted below in Item 4.
4. ECU is required to grant my request for restriction on disclosure of PHI when such disclosure is (i) to a health plan for purposes of carrying out payment or health care operations; and (ii) such PHI pertains solely to a health care item or service I received for which the Health Care Component on the relevant date of service has been paid out of pocket in full.
5. If ECU grants my request for restrictions, the restricted information will not be used or disclosed except to provide treatment to me in an emergency.
6. Any agreement to a restriction (except a restriction approved under Item 4 above) at any time by either me or an ECU Health Care Component can be terminated by notifying the other party. If ECU terminates its agreement to a restriction, it will notify me, and will continue to comply, if possible, with the restriction for any information that was created prior to the date of termination.

I would like to request that the following **previously approved** restrictions with respect to my PHI be terminated:

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_____ _____
Date Please Print Name of Patient

_____ _____
Patient Date of Birth Signature of Patient, Parent, Guardian or Personal Representative (Parent or Legal Guardian must sign for anyone under 18yrs of age)

_____ _____
Relationship to Patient Please Print Name of Parent, Guardian or Personal Representative

Mail Request for Termination of Restrictions to:

ECU HIPAA Privacy Officer
Physicians Quadrangle N, 600 Moye Blvd
Greenville, NC 27834
Phone 252-744-5200