UCLA DENTAL CLINICS
TERMINATION OF SPECIAL RESTRICTION

Patient Name:_____
Date of Birth:_____

A special restriction of the use or disclosure of protected health information for the above named patient was requested on _____ (insert date). I request that the special restriction be terminated.

_____

Patient Signature

_____ _____

Patient Name Date

OR

_____ _____

Patient's Representative Signature Relationship

_____ _____

Patient's Representative Name Date

When you have completed this form, please return it to:

Dr. Sean Mong
General Clinic Director
UCLA School of Dentistry
Box 951668
10-136 Center for the Health Sciences
Los Angeles, CA 90095-1668

Please provide the following contact information to be sent our response below:

Address:_____

_____

Telephone:_____
Email: _____

The UCLA Dental Clinics hereby inform you that your special restriction on the use or disclosure of protected health information dated _____is terminated. The termination is only effective with respect to protected health information created or received by the UCLA Dental Clinics after you have received this notification.

_____

Patient Signature

_____ _____

Patient Name Date

OR

_____ _____

Patient's Representative Signature Relationship

_____ _____

Patient's Representative Name Date