



MODIFICATION/ TERMINATION OF RESTRICTION

This is a modification or termination of the patient's request of ___/___/___ for a restriction of his/her information.

This modification or termination is a result of a request from:

- ☐ Patient
- ☐ University Physicians of Brooklyn, Inc.

MODIFICATION: The patient's request for restriction is being modified in the following manner:

TERMINATION: The patient's request for restriction is being terminated. Document reason (if any):

- ☐ Patient agrees to modification/ termination.

Signature of Patient or Personal Representative

Date

- ☐ Patient orally agrees to modification/ termination.

Signature of UPB Member

Date

- ☐ Patient does not agree to modification/ termination.

Modification/ Termination is only applicable after patient notification date of ___/___/___.

THIS FORM MUST BE PLACED IN THE PATIENT'S MEDICAL RECORD ON TOP OF THE NOTICE OF ADDITIONAL PRIVACY PROTECTION REQUEST REVIEW FORM.