Termination of Authorization or Restriction

US FAMILY HEALTH PLAN

This form may be used to terminate a previously granted authorization or a requested restriction.
All fields are required. Incomplete or incorrect forms will be returned to the member's address on file.

Member Information – For individual making the termination request ("Member")	
Name:	**ID Number:**
Street Address:	
City, State, Zip Code:	
Date of Birth:	**Phone Number:**

Termination Request – Member hereby requests US Family Health Plan (USFHP)* to terminate the following:	
☐ Authorization to Disclose PHI	Recipient Name:
☐ Designation of Representative	Representative Name:
☐ Restriction Request	Restricted Individual Name:

Signature

I represent that the signature below is my own and that I am legally authorized to sign this document.

Signature of Member or Personal Representative**

Date

Printed Name

Relationship, if not Member**

**This Termination will only be valid if signed by Member, the parent or guardian of Member (if Member is a minor), or Member's Personal Representative (e.g., power of attorney, health care proxy, etc.). If you are not Member, please indicate your relationship to Member above and submit a copy of the applicable legal documentation if you are a Personal Representative (if not already provided).

Please return completed form and supporting legal documentation (if applicable) to:

Via FAX:	**Via MAIL:**
ATTN: Member Services 1-617-673-0380	Tufts Health Plan ATTN: Member Services - USFHP 1 Wellness Way Canton, MA 02021-1166

If you have any questions about this form, please contact a Tufts Health Plan Member Services representative at: 1-800-462-0224 or TTD# 711.

*For purposes of this Termination, USFHP refers to Tufts Health Plan and includes Harvard Pilgrim Health Care, Inc., Harvard Pilgrim Health Care of New England, Inc., HPHC Insurance Company, Inc., Harvard Pilgrim Group Health Plan, Tufts Associated Health Maintenance Organization, Inc., Tufts Health Public Plans, Inc., Tufts Insurance Company, CarePartners of Connecticut, Inc., and Tufts Associated Health Plans, Inc., and all of their present and future affiliates. This Authorization also applies to vendors acting on behalf of the above-named entities.