

Revocation of Prior Authorization for the Use and Disclosure of Protected Health Information

First Name:	Member Information (Person whose information will no longer be disclosed)			
Member ID:	First Name:	Last Name:		
City: State: Zip: Revocation of Previously Authorized PHI Select the information you wish to restrict from the previously granted authorization. Ino longer grant authorization to PHII, as indicted below: ALL Protected Health Information (PHII) Mental Health HIIV Substance Use Other (specify here): Previously Authorized Individual (Person who is no longer authorized to access PHI) Identify the Individual or Entity that was previously authorized below. Name: Relationship: Date of Birth: Address: City: State: Zip: I understand that I am submitting a request to revoke disclosure of Member's Protected Health Information (PHI) to the Previously Authorized Individual, as indicated above. I understand that the revocation will not apply to information that has been released under prior authorization and that after information is disclosed, it can be redisclosed by the recipient and the information may not be protected by federal privacy regulations. Member or Legal Representative Signature Date If Legal Representative signs, must provide documentation to support legal authority to act on behalf of Member. If Revoked by a Legal Representative, Print Name: Address:				
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Ino longer grant authorization to PHI, as indicted below: ALL Protected Health Information (PHI)	·			
ALL Protected Health Information (PHI) Mental Health			uthorization.	
Mental Health	I no longer grant authorization to PHI, as indi	cted below:		
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