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

Member Information *(Person whose information will no longer be disclosed)*

First Name: _____ Last Name: _____

Member ID: _____ Date of Birth: _____

Address: _____

City: _____ State: _____ Zip: _____

Revocation of Previously Authorized PHI

Select the information you wish to restrict from the previously granted authorization.

I no longer grant authorization to PHI, as indicted below:

☐ ALL Protected Health Information (PHI)

☐ Mental Health ☐ HIV ☐ 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: _____ Phone: _____

City: _____ State: _____ Zip: _____