Health Tradition Health Plan

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REVOCATION OF AUTHORIZATION FOR DISCLOSURE OF INFORMATION

SECTION A: Individual revoking the authorization.

Member Name _____ Insurance ID#: _____

Date of Birth _____/_____/_____ Phone Number (Home) _____-_____-_____ (Work) _____-_____-_____

Member Address _____

_____

SECTION B: Statement of revocation.

I revoke my previous authorization for your disclosure of my protected health information as described below.

I understand that this revocation of my authorization will *not* affect any action you or others took in reliance on my authorization before they received this written notice of my revocation. I also understand that, if my authorization was a condition of my enrollment in your health plan or of my eligibility for benefits, or was for protected health information that you requested to process payment of a claim involving me, you may disenroll me from the health plan, end my eligibility for the benefits, or not pay the claim.

Copy of authorization attached: ☐ Yes (If yes, proceed to Section D.)

☐ No (If no, fill in Section C to the best of your ability.)

SECTION C: Description of authorization revoked to the best of your ability (complete if authorization not attached).

Date of authorization (if known): ____/____/____

Protected Health Information: The revoked authorization included the following protected health information:

_____

_____

Entities Authorized to Receive: The revoked authorization included the following persons and/or organizations (or classes of persons and/or organizations) that were authorized to receive the protected health information described above:

_____ _____

_____ _____

SECTION D: Individual's Signature.

Print Name: _____

Signature: _____ Date: _____

If this revocation is signed by an Authorized Representative on behalf of the individual, complete the following:

Authorized Representative's Name: _____

Relationship to Individual: _____

YOU ARE ENTITLED TO A COPY OF THIS AUTHORIZATION REVOCATION AFTER YOU SIGN IT.