

## END AUTHORIZATION TO SHARE HEALTH INFORMATION

If you want Health Tradition to stop sharing your health information with a person or agency that you authorized in the past, complete the **End Authorization to Share Health Information** form.

### INSTRUCTIONS FOR COMPLETION

1. Print or type.
2. Use blue or black ink.
3. **Individual's Name:** Your name or your dependent's name.
4. **Birth date:** Your birthdate or your dependent's birthdate.
5. **Subscriber Number/Group Number:** Your (or your dependent's) Health Tradition subscriber number and group number.
6. **End Authorization:** Who is the person or agency that should no longer receive your health information?
7. **Individual's Signature:** The person from #3 must sign the form.
  - If a dependent is under 18, the parent/legal representative must sign the form.
  - If an adult cannot sign the form, the parent/legal representative must sign the form and write why they are signing (disability or health condition).
8. **Date:** What date are you signing the form?
9. Send the form to:

Health Tradition  
Attn.: Office of General Counsel  
45 Nob Hill Road  
Madison, WI 53713-3959

Fax: (608) 661-6626, Attn.: Office of General Counsel

**END AUTHORIZATION TO SHARE HEALTH INFORMATION**

**Individual's Name:** \_\_\_\_\_ **Individual's Birth Date:** \_\_\_\_\_

**Subscriber Number:** \_\_\_\_\_ **Group Number:** \_\_\_\_\_

**End Authorization**

I want Health Tradition to stop sharing my health information with: \_\_\_\_\_

I understand that I gave Health Tradition permission to share my health information with this person or agency in the past. I cannot change any information Health Tradition shared before receiving this form.

\_\_\_\_\_  
**Individual's Signature**

\_\_\_\_\_  
**Date**

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