AUTHORIZATION REVOCATION

(Note: If the form is not complete, signed, and dated, it becomes invalid and cannot be accepted.)

Please Print or Type.

SECTION A: Statement of Revocation.

I hereby revoke my authorization of the use and/or disclosure of **my identifiable health information as described below.** I understand that revocation of this authorization will not affect any action that my Health Plan, or others named or unnamed herein, took before my Health Plan received my written notice of revocation. I also understand that if my authorization was a condition of my enrollment into the Health Plan or eligibility for benefits, the Health Plan may disenroll me or end my benefits. I also understand that if the authorization was requested to adjudicate payment of a claim on my behalf, the Health Plan may refuse payment of the claim.

Last Name: _____ **First Name:** _____ MI: ___

If not the Policy Holder, **Name of Policy Holder: Last Name:** _____ **First Name:** _____

Street Address: _____ Apt #: _____

City: _____ **State:** _____ **Zip:** _____

Phone: (home) _____ **(work)** _____

Member # (include 3 letter prefix): _____ **Date of Birth:** ____/____/_____

SECTION B: Description of Authorization Revoked.

Health Plan or Business Associate Authorized to Discontinue Releasing Information: Identify the health plan or health plan administrator (as it appears on your health benefits identification card) that is authorized to discontinue releasing your health information:

_____ BlueChoice _____BluePreferred (PPO)
_____ Indemnity _____ MD Point of Service
_____ Preferred Provider Organization (PPO)
_____ Other _____

Individuals/Organizations affected by this revocation: Identify the individual or organization to whom you no longer wish the health plan or health plan administrator to release information (e.g., the person's name, the broker's name or firm, the disability company etc):

_____
_____

Type of Health Information to be revoked from use and/or disclosure: Provide a written description of the health information you no longer wish to have used or disclosed by your health plan or health plan administrator OR select the type of information from the options provided here (check all that apply):

_____
_____
_____

(1) Claims Information, including payment status and/or procedure/service or condition (select those that apply):

_____ ALL _____ Medical
_____ Dental _____ Vision
_____ Prescription _____ Mental Health
_____ Substance Abuse _____Other

(2) Premium Payment Information (select those that apply):

_____ ALL _____ Medical _____ Dental
_____ Vision _____ Prescription

(3) Information related only to this procedure/service or condition: (e.g. Heart Surgery or Pregnancy)

_____
_____

SECTION C: Signature

I, _____, have had full opportunity to read and consider the contents of this revocation, and I confirm that the contents are consistent with my direction to my health plan or health plan administrator. I understand that by signing this form, I am confirming my revocation that my health plan or health plan administrator may no longer use and/or disclose the protected health information described above to the persons and/or organizations named in this form.

Signature: _____ Date: _____

If a personal representative signs this revocation on behalf of the Individual, complete the following:

Personal Representative's Name: _____

Relationship to Individual: _____

____ Health plan or health plan administrator already has a copy of the form designating me as the personal representative on file.

____ Attached is a copy of the form designating me as the personal representative.

Please mail or fax the completed Authorization Revocation Form to:

CareFirst Privacy Office
c/o CareFirst BlueCross BlueShield
10455 Mill Run Circle, TBP-06
Owings Mills, MD 21117
Fax: 410-561-7988

We will provide you with a copy of this revocation. Please make and keep a copy of it for your records prior to sending it to the health plan, health plan administrator or other party.