

# Health Tradition Health Plan

P.O. Box 188 La Crosse, WI 54602-0188  
1-608-781-9692 1-888-459-3020 Fax 1-608-781-9653

## REVOCAION 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.**