Authorization to Revoke Release of Health Information

I do hereby request that the prior authorization to release the health information of

_____
Name of Health Plan Member

to _____
Name of Authorized Representative

be rescinded effective _____.
Date

I understand that any release of information prior to my request to rescind the authorization is legal and binding.

_____ _____
Signature of Health Plan Member Date

_____
Member #

_____ _____
*Signature of Personal Representative Date

_____
Personal Representative Relationship/Authority

*** In order for the Signature of a Personal Representative to be used, the Health Plan Member must be incapacitated to the point of being unable to make health related decisions for themselves. If this is signed by a Personal Representative, then the Personal Representative Relationship/Authority line must be completed, and guardianship or Power of Attorney paperwork must be provided.**

For EBD Use Only

System ID#: _____

Completed by: _____

Employee Benefits Division
501 Woodlane Street, Suite 500 * Little Rock, AR 72201 * 501.682.9656
TRANSFORM.AR.GOV