GEHA

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REVOCATION OF AUTHORIZATION TO USE OR DISCLOSE PROTECTED HEALTH INFORMATION

About You

Plan ID Number: _____

Your Name: _____ **Date of Birth:** _____

Address: _____

Telephone Number: _____

Please place a check mark in front of each plan you want this Revocation of Authorization to be applied:

- ☐ GEHA Health Plan
- ☐ GEHA Connection Dental Federal Plan
- ☐ Connection Dental *Plus* Plan
- ☐ CONNECTION Vision Plan

Revocation Information

I previously authorized Government Employees Health Association, Inc. ("GEHA") and its business associates to release my protected health information to the following persons, and now wish to revoke these prior authorizations:

Name(s): _____

Relationship(s) to You: _____

Signature and Acknowledgement

By signing below, I hereby revoke such prior Authorization(s). I understand that protected health information may already have been disclosed by GEHA pursuant to and in reliance on my prior Authorization. I also understand that this revocation applies only to the information specifically described in the "AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION" form previously signed and sent to GEHA. **I understand that this revocation request may require up to fifteen (15) working days from the date received by GEHA to process this request**.

Date: _____

Patient or Legal Representative Signature: _____

Relationship to Patient: _____
(i.e. parent, legal guardian, power of attorney, etc.)

NOTE: If the signature is not that of the patient or the parent when the child is a minor, appropriate legal documentation is required to accept the signature.

YOU ARE ENTITLED TO A COPY OF THIS REVOCATION OF AUTHORIZATION FORM AFTER YOU SIGN IT. PLEASE RETAIN A COPY FOR YOUR RECORDS AND RETURN THE ORIGINAL SIGNED FORM TO:

ATTN: Authorization Revocation
GEHA
P.O. Box 21542
Eagan, MN 55121
FAX: 816-257-3283