GEHA

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REVOCATION OF AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

This form is for subscribers and members covered by the GEHA Health, GEHA Connection Dental Federal, CONNECTION Dental *Plus* plans and/or Connection Vision Plan. Please place a check mark in front of each plan you want this Revocation of Authorization request to be applied.

NOTE: At least one line MUST be checked for this form to be valid.

- ☐ GEHA Health Plan (includes Connection Vision Plan)
- ☐ GEHA Connection Dental Federal Plan (includes Connection Vision Plan)
- ☐ CONNECTION Dental *Plus* Plan (includes Connection Vision Plan)
- ☐ CONNECTION Vision Plan only

NOTE: ALL AREAS OF THIS FORM MUST BE COMPLETED IN FULL. INCOMPLETE FORMS WILL BE CONSIDERED INVALID AND RETURNED.

Subscriber/Member Information:

Subscriber Name: _____

Address: _____

Subscriber ID Number: _____ **Telephone Number:** _____

Patient Name: _____ **Date of Birth:** _____

I previously signed an Authorization to Release Health Information by designating the following person(s) for GEHA to disclose my protected health information:

Authorized Person #1:

Name: _____ **Phone Number:** _____

Address: _____

Relationship to You: _____

Authorized Person #2:

Name: _____ **Phone Number:** _____

Address: _____

Relationship to You: _____

I hereby revoke such Authorization effective the date signed below, but **understand that this will require up to fifteen (15) working days from the date received by GEHA to execute this request and forward to GEHA's business associates, who partner with us to assist in providing services in areas such as pharmacy, radiology, precertification, vision, etc.** (as outlined in GEHA's Notice of Privacy Practices available at www.geha.com), and information may continue to be disclosed up to that time. I understand that protected health information may already have been disclosed 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. It does not affect any prior executed Authorizations to release information for any other purpose, such as medical records in regard to determining payment to a provider.

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:

GEHA
ATTN: Authorization Revocation
P.O. Box 438
Independence, MO 64051-0438
FAX: 816-257-3283