



Department of Transformation and Shared Services

Governor Asa Hutchinson

Secretary Amy Fecher

Director Jake Bleed

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be rescinded effective _____.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

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