



REVOCATION OF AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

Participant Name: _____ Birth Date: _____

Address: _____

Home Telephone Number: _____ Work Telephone Number: _____

E-mail Address: _____ Participant Social Security Number: _____

I do hereby request that my authorization to disclose health information to _____
_____ be revoked, effective _____.

I understand that this revocation will not have any effect on any action that the MPI Health Plan took prior to the effective date of this revocation.

I have had an opportunity to review and understand the contents of this form. By signing this form, I am confirming that it accurately reflects my wishes.

Participant Signature _____ / /
Date

If this Revocation is to be signed by a personal representative, complete the following:

Name of personal representative: *(Please print)* _____

Relationship to Participant or nature of authority (e.g., health care power of attorney, guardian, other statutory authorization): _____

Address: _____

Home Telephone Number: _____ Work Telephone Number: _____

E-mail Address: _____

Signature of Personal Representative _____ / /
Date

**RETURN FULLY COMPLETED FORM TO THE PLAN OFFICE AT THE MAILING ADDRESS BELOW,
“ATTENTION: CLAIMS REVIEW UNIT”**