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"

11365 VENTURA BOULEVARD · STUDIO CITY, CALIFORNIA 91604-3148
MAILING ADDRESS: P.O. BOX 1999 · STUDIO CITY, CALIFORNIA 91614-0999
818 OR 310.769.0007 · WWW.MPIPHP.ORG