GEHA

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REVOCATION OF AUTHORIZATION TO USE OR DISCLOSE PROTECTED HEALTH INFORMATION ("PHI")

Use this form to revoke permission for GEHA to discuss your PHI with the authorized person(s) listed below.

About you, the GEHA member whose PHI may no longer be used or disclosed

Plan ID Number: _____

Member 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 PHI 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 PHI 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