Revocation of HIPAA* General Authorization for Disclosure of Protected Health Information (PHI)/Electronic Protected Health Information (ePHI)

Health Insurance Portability and Accountability Act of 1996

St. Louis – Kansas City Carpenters Regional Health Plan (Plan)
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This form revokes or terminates permission to disclose PHI/ePHI to a previously authorized Person or Entity.

A. Participant terminating authorization to disclose protected health information – Please PRINT:

Participant Last Name	Participant First Name	Participant Middle Name

Date of Birth	Last 4 Participant SSN	Best Contact Phone Number

B. Revocation of Authorization – Please PRINT:

I revoke any authorizations I have previously given to the Plan to disclose my protected health information to the following Person or Entity.

Full Name of Person or Entity previously authorized to receive PHI/ePHI:	Relationship	Phone Number
Full Name of Person or Entity previously authorized to receive PHI/ePHI:	Relationship	Phone Number

The Plan may no longer disclose the following PHI/ePHI to the Person/Entity listed above (choose all that apply):

☐ Entire Medical Record ☐ Mental/Behavioral Health Information, excludes Psychotherapy Notes

☐ Genetic Information ☐ Other, please list: _____

Important Information Concerning Participant Rights

1. The Participant is the member or dependent covered under the St. Louis – Kansas City Carpenters Regional Health Plan.
2. Participant signature on this form will not affect your treatment, payment, enrollment in health plan or eligibility for benefits.
3. Upon request, a copy of this signed Authorization will be sent to the Participant listed in Section A.
4. If signed by a legally authorized Personal Representative (Power of Attorney, etc.), legal documentation must be attached.
5. Any revocation will not apply to any action that the Plan may have already taken on the Participant's behalf before receipt of the signed Revocation of HIPAA Authorization Form.

C. Participant's Signed Revocation:

By completing and signing this form, I understand and agree I am now revoking my prior HIPAA Authorization to release my PHI/ePHI to the person or entity listed above. I also understand that this revocation will not affect any action the Plan may have already taken in reliance on my authorization before they receive this written notice.

Participant Signature **Date**

(Signature of Parent if Participant is a minor under the age of 18) or (Legal Personal Representative, see #7 above)

Legal Personal Representative's Name – please print *(if applicable)* **Personal Representative's Phone Number**

For office use only