REVOCATION OF AUTHORIZATION OR DESIGNATION OF PERSONAL REPRESENTATIVE

This form is to revoke an authorization or personal representative designation. Completing and submitting this revocation to the health plan/CareFirst® Administrators (CFA) allows you to rescind your original authorization or personal representative designation. This revocation will be effective once it is entered into our systems which is typically 5 business days from receipt.

Please print neatly to ensure correct and prompt processing. We reserve the right to return any illegible or incomplete form.

1) State of Revocation:

Please select the option that fits your need.

____ I hereby revoke **my authorization** for release of protected health information.

____ I hereby revoke **my designation of a personal representative**.

I understand that this revocation will not affect any action that the health plan/CFA or health plan administrator took before receiving my written notice of revocation. I also understand that if the authorization was requested to adjudicate payment of a claim on my behalf, my revocation may result in the health plan/CFA or health plan administrator refusing payment of the claim.

2) Member Revoking the Release of Information:

Name: ____ Date of Birth: ____/ ____/____

Membership Number: ____

Address: ____

Home Phone: ______________________________ Work Phone: ____________________

Health Plan Name or Employer Name: ____

3) At my request, I want to revoke the release of my protected health information to:

A. Name of Individual or Organization: ____

Address: ____

City, State, Zip: ____

Telephone: ____

B. Name of Individual or Organization: ______________________________________

Address: ____

City, State, Zip: ____

Telephone: ____

I, ______________________________, understand that by signing this form, I am confirming my revocation that the health plan/CFA or health plan administrator may no longer use and/or disclose my protected health information to the persons and/or organization named in this form.

Signature: __________________________________ **Date:** ________________

If the person signing this revocation is not the member, or the parent/guardian or a dependent under the age of 18, you must attach a full copy of the official document indicating your legal authority to sign on behalf of the member (i.e. Power of Attorney, Court Assigned Guardian, Personal Representative, etc.)

Please mail or fax this revocation form to:

CareFirst Administrators – Privacy Coordinator
1501 S. Clinton Street
7th Floor
Baltimore, MD 21224
Fax: 703-654-6412
Toll Free Fax: 877-332-2367

Please keep a copy of the revocation.
We will provide you with a signed copy of this revocation upon request.

Any mental health or substance abuse information, which has been disclosed from medical or other health care records, may be protected by federal and/or state law. If the records are so protected, Federal Regulation (42CFR Part 2) prohibits the recipient of the information from making any further disclosure of this information unless such disclosure is expressly permitted by the written consent of the person to who it pertains, or as otherwise permitted by 42 CFR Part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.