PO Box 211256
Eagan, MN 55121-2656

UniveraHealthcare.com

Protected Health Information Authorization Revocation Form

PLEASE PRINT

PURPOSE:

This form should be completed when a member wishes to revoke an existing authorization permitting Univera Healthcare to release protected health information (PHI) to another person or organization.

If there is currently more than one person to whom we are authorized to disclose, the name of each person to which this revocation applies must be listed in Part B. If you only list one person, only the authorization for that person will be revoked. You can revoke the authorization for up to two people or organizations on this form. If you need to revoke the authorization for more than two people or organizations, additional forms need to be completed.

We can only process your revocation request if your signature is included below. If the effective date of revocation is left blank, then the authorization will be revoked as of the date the form is received.

Please complete all sections if you wish to revoke your authorization(s).

PART A: INDIVIDUAL WHO IS THE SUBJECT OF THE CURRENT AUTHORIZATION

LAST NAME	FIRST NAME	MI	DATE OF BIRTH	IDENTIFICATION # - located on ID card(s)

CURRENT ADDRESS	CITY	STATE/ZIP CODE

PART B: I WISH TO REVOKE MY AUTHORIZATION PERMITTING UNIVERA HEALTHCARE TO SHARE MY INFORMATION WITH THE FOLLOWING PERSON(S) AS OF THE EFFECTIVE DATE OF REVOCATION

NAME OF PERSON/ORGANIZATION	EFFECTIVE DATE OF REVOCATION
NAME OF PERSON/ORGANIZATION	EFFECTIVE DATE OF REVOCATION

PART C: ACKNOWLEDGEMENT (PLEASE READ AND SIGN)

I have had full opportunity to read and consider the contents of this authorization revocation form. I understand that, by signing this form, I am confirming that the information contained on this form is correct.

I understand that revocation of the authorization will not affect any action taken in reliance on this authorization before written notice of revocation is received.

Signature:_____ **Date:** _____

If this request is from a personal representative on behalf of the member, complete the following:

Personal Representative's Name: _____

Personal Representative Signature _____

Description of Authority: ☐ Parent ☐ Legal Guardian* ☐ Power of Attorney* ☐ Other * _____

** You must provide documentation supporting your legal authority to act on behalf of the member*

Please complete and return this form to:
Univera Healthcare, P.O. Box 211256 Eagan, MN 55121-2656
or Fax: 315-671-7079

PLEASE MAKE A COPY OF THIS FORM FOR YOUR RECORDS