Revocation of Authorization to Use and/or Disclose Health Information

I want to cancel, or revoke, the permission I gave to Managed Health Services (MHS) to use my health information for a particular purpose or to share my health information with a person or group:

PERSON OR GROUP THAT RECEIVED THE INFORMATION:

Name (person or group): _____

Address:_____

City: _____ State: _____ Zip: _____ Phone: (_____) ____ - _____

Authorization Signed Date (if known): / _____ /_____

MEMBER INFORMATION:

Member Name (print): _____

Member Date of Birth: _____ / _____/ _____ Member ID Number:_____

I understand that my health information (including, where applicable, my substance use disorder records) may have already been used or shared because of the permission I gave before. I also understand that this cancellation only applies to the permission I gave to use my health information for a particular purpose or to share my health information with the person or group. It does not cancel any other authorization forms I signed for health information to be used for another purpose or shared with another person or group.

Member Signature: _____ **Date:** _____ / _____/ _____

(Member or Legal Representative Sign Here)

If you are signing for the Member, describe your relationship below. If you are the Member's personal representative, describe this below and send us copies of those forms (such as power of attorney or order of guardianship).

_____

MHS will stop using or sharing your health information when we receive and process this form. Use the mailing address below. You can also call for help at the number below.

MHS
Attn: Compliance Department
550 N. Meridian St., Suite 101
Indianapolis, IN 46204
Phone: 1-877-647-4848