Revocation of Authorization for the Release of Protected Health Information (PHI)

BlueCross BlueShield Kansas

Previously, you completed an Authorization for the Release of Protected Health Information (PHI) Form allowing Blue Cross and Blue Shield of Kansas (Blue Cross) to share your PHI with a person, category, or entity. It is your right to revoke that authorization at any time and for any reason. It is required that Blue Cross receive the request in writing. By completing the fields on this form that apply to you, Blue Cross will no longer share your PHI with the indicated person, category or people, or entity.

Section 1: Member who is revoking authorization

Print Name

Enrollee ID (number on your card beginning with one to three letters)

(_____) _____-_____
Phone Number

Address

City

State

ZIP Code

+4

Section 2 – Revocation

☐ I revoke my authorization for use and disclosure of my protected health information described in my original authorization (or as described in Section 3 below).

☐ I revoke my authorization for use and disclosure of substance abuse records described in my original authorization (or as described in Section 3 below).

Is a copy of original authorization attached? ☐ Yes ☐ No (Please complete Section 3)

I understand that this revocation will not affect actions taken in accordance with my original authorization prior to receipt of this written revocation.

Section 3 – Description of authorization you are revoking (Complete this section if you checked "No" in Section 2)

Date of authorization (if known): _____ / _____ / _____.

Describe in detail the persons or entities and the information the original authorization applied to (person who was authorized to receive protected health information, dates of treatment, type of service, etc.):

☐ **Disclosure Blue Cross and Blue Shield of Kansas:** I am revoking my authorization for Blue Cross to use and disclose the protected health information described above.

☐ **Disclosure Blue Cross and Blue Shield of Kansas:** The revoked authorization allowed Blue Cross to receive and use protected health information described above.

Please continue on the next page.

Section 4 – Member signature

_____ _____ / _____ / _____
Signature of member Date Signed

Section 5 – Personal representative

If you are not the member, please sign and date below then check the box that describes your relationship to the member. **Please attach proof of your relationship to the member (e.g., power of attorney, personal representative documentation, etc.).**

_____
Printed name personal representative

_____ _____ / _____ / _____
Signature of personal representative Date Signed

☐ Legal guardian ☐ Power of attorney ☐ Executor ☐ Other

IMPORTANT: Please read the form over carefully and be sure you have included all necessary information. We cannot take additional information by phone, fax or email. If information is missing, we will have to contact you and request a new form.

Mail completed revocation form to:

BCBSKS Member Correspondence
P.O. Box 211355
Eagan, MN 55121

or fax to: 800-426-6535

For additional assistance completing this form, please call Customer service at 800-222-7645 (TTY 711).
ATTENTION: If you speak Spanish, language assistance services, free of charge, are available to you. Call 800-222-7645 (TTY 711).
ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 800-222-7645 (TTY: 711).