



## REVOCATION OF AUTHORIZATION TO DISCLOSE PERSONAL & HEALTH INFORMATION TO A THIRD PARTY

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Purpose: This form is used to revoke authorization to disclose personal and health information previously given to Blue Shield of California.

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### **SECTION A: Statement of Revocation**

I revoke my authorization for "Blue Shield" to disclose my personal and health information as described below.

I understand that revocation of my authorization will *not* affect any action "Blue Shield" or others took in reliance on my authorization before they received this written notice of my revocation.

Initials: \_\_\_\_\_

Name: \_\_\_\_\_

Address: \_\_\_\_\_

Telephone: \_\_\_\_\_

Subscriber Number:

\_\_\_\_\_

Member Number: \_\_\_\_\_

Member Date of Birth:

\_\_\_\_\_

Date of authorization (if known): \_\_\_\_\_

### **SECTION B: Description of Revoked Authorization**

**Personal and Health Information:** The revoked authorization allowed for the use and/or disclosure of the following personal and health information:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Entities Authorized to Receive and Use:** The revoked authorization allowed the following persons and/or organizations (or classes of persons and/or organizations) to receive and/or use the personal and health information described above:

\_\_\_\_\_  
\_\_\_\_\_

**SIGNATURE**

Signature: \_\_\_\_\_

Date: \_\_\_\_\_

Print Name: \_\_\_\_\_

Person or Entity Revoking the Authorization for Disclosure of Personal and Health Information: If you are signing on behalf of the member, please indicate your relationship to the member and provide copies of verification of your legal right to make decisions regarding the member's personal and health information.

- Parent or guardian of minor patient (to the extent minor could not have consented to the care)
- Court appointed guardian or legal conservator of an incompetent patient or representative with Power of Attorney to disclose the member's personal and health information
- Durable Power of Attorney for Health Care
- Beneficiary or personal representative of deceased patient
- Spouse or person financially responsible (where information is solely for purpose of processing an application for enrollment)

**YOU ARE ENTITLED TO A COPY OF THIS REVOCATION OF AUTHORIZATION AFTER YOU SIGN IT. A COPY OF THIS REVOCATION SHALL BE CONSIDERED AS EFFECTIVE AND VALID AS THE ORIGINAL.**