CountyCare HEALTH PLAN

Return To: CountyCare Health Plan
P.O. Box 211592
Eagan, MN 55121

REVOCATION OF AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION (PHI)

I. MEMBER: (Name and information of person whose protected health information was shared.)

Name: _____

Address: _____

Member ID #: _____ **Date of Birth:** _____

II. REVOCATION

I want to cancel, or revoke, the permission I gave to CountyCare to discuss or disclose my personal and health information with this person or group:

Name of Person authorized to receive PHI: _____

Relationship to Member: _____

Address: _____

City: _____ **Zip:** _____

Authorization signed date (if known): _____

I understand that my health information may have already been shared because of the permission I gave before. I also understand that this cancellation only applies to the permission I gave to share my health information with this person or group. It does not cancel any other authorization forms I signed for health information to be shared with another person or group.

Signature of Member: _____ **Date:** _____

Signature of Representative (if applicable): _____

CountyCare will stop sharing your protected health information (PHI) when we get this form. Use the mailing address or fax number at the top of this form. You can also call for help at (312) 864-8200 or (855) 671-8883 (toll-free)/711 (TDD/TTY).