‘OHANA HIPAA RELEASE OF INFORMATION REVOCATION FORM

This form is used to confirm the revocation of the Member’s permission that the Health Plan* may discuss or disclose Protected Health Information (PHI) to a particular person who acts as the Member’s Personal Representative.

Section A – Revocation of Permission to Release Information

By signing this form, I understand and agree that I am now revoking my prior permission that I provided to the Health Plan and signed and dated on _____ (mm/dd/yyyy), to release my PHI to my Personal Representative. That permission allowed the Health Plan to release, use and disclose my PHI to the person named in **Section B** below.

I understand that this revocation does not apply to any action the Health Plan has taken in reliance on the authorization I previously signed. In addition, I understand that this revocation does not revoke any other authorizations to release information that I have provided to the Health Plan.

Print Name of Member: Date of Birth: (mm/dd/yyyy)

Address:

Telephone Number: Member ID Number:

Medicare ID Number: Medicaid Number:

*The Health Plan is ‘Ohana Health Plan ("‘Ohana"). This release applies to each of the following Health Plans: Easy Choice Health Plan, Inc., Exactus Pharmacy Solutions, Inc., WellCare of Florida, Inc. operating in Florida as HealthEase and Staywell, WellCare of New York, Inc., WellCare of Connecticut, Inc., WellCare of Louisiana, Inc., WellCare Prescription Insurance, Inc., Harmony Health Plan of Illinois, Inc. operating in Missouri as Harmony Health Plan of Missouri, Harmony Health Plan of Illinois, Inc., WellCare of Georgia, Inc., WellCare of Ohio, Inc., WellCare Health Insurance of Arizona, Inc. operating in Hawaii as ‘Ohana Health Plan, Inc., WellCare of Texas, Inc. operating in Arizona as WellCare of Arizona, Inc., WellCare Health Insurance of Kentucky, Inc. operating in Kentucky as WellCare of Kentucky, Inc., WellCare of South Carolina, Inc., Missouri Care, Incorporated, and WellCare Health Plans of New Jersey, Inc.

Section B - Personal Representative

Name: Date of Birth (mm/dd/yyyy):

Address:

Relationship to You: Telephone Number:

Section C – Effective Date of Revocation

This revocation of permission to use or disclose protected health information is effective _____/_____/_____.
mm dd yyyy

Section D – Signature/Authorization

_____
Signature of Member/Personal Representative (if applicable)

Date: _____