Protected Health Information Authorization Cancellation Form

Purpose: This form should be completed when a member wishes to cancel an existing authorization permitting YourCare Health Plan to release protected health information (PHI) to another individual or organization. **If there is currently more than one person authorized, the individual names must be listed below. If you only list one individual, only the authorization for that individual will be revoked.**

Please complete both sections if you wish to cancel your authorization.

I. I wish to revoke my authorization permitting YourCare Health Plan to release my PHI to

_____

_____

II. Member number_____

Effective date of cancellation _____

Signature: You may refuse to sign this. However, without a signature, we cannot process your cancellation request.

I, *(please print)* _____, have had full opportunity to read and consider the contents of this authorization revocation form. I understand that, by signing this form, I am confirming that the information contained on this form is correct.

I understand that revocation of the authorization will not affect any action taken in reliance on this authorization before written notice of revocation is received.

Signature: _____ Date: _____

If a personal representative on behalf of the individual signs this, please complete the following:

Personal Representative's Name: *(please print)* _____

Description of Authority: _____

Personal Representative's Signature: _____

Date: _____

Please complete and return this form
to: YourCare Health Plan
P.O. Box 240
Pittsford, NY 14534

PLEASE MAKE A COPY OF THIS FORM FOR YOUR RECORDS