



REVOCAION OF AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

Instructions:

By signing this form, you can revoke (end/terminate) a previously signed Authorization for Release of Protected Health Information (PHI) or other authorization form. Send this signed form to the attention of Privacy Officer at P. O. Box 1511, Flint, MI 48501-1511, via fax at (810) 213-0406, or scan and email to mhpcompliance@mcclaren.org.

Name:	Daytime phone number:
Complete address:	Contract number:
Name of person whose authorization you are revoking: (If more than one, list all here.)	

By signing below, I revoke the written authorization form for the above-named person or persons previously given to McLaren Health Plan, McLaren Health Plan Community or McLaren Health Advantage.

I understand this revocation will not affect any of the actions taken before McLaren receives the written revocation. Please note that your revocation will take effect once McLaren receives **and** processes the revocation. A member or the member’s legally authorized representative may not revoke a disclosure that is required under HIPAA.

Member signature

Date

Signature of other person legally authorized to revoke authorization on behalf of member (i.e., legal guardian, power of attorney for health care, etc.)

Date

For McLaren use only	Date received: _____
Date entered in system: _____	

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McLarenHealthPlan.org