VOCATION OF AUTHORIZATION

Section A: Statement of Revocation

I revoke my previous authorization, or part of my previous authorization, for the Indiana Health Coverage Program's (IHCP's) use and disclosure of my health information records as described below.

I understand that this revocation of my authorization will *not* affect any action the IHCP or others took in reliance on my authorization before receiving this written notice of my revocation.

Initials: ____________

Name: ____________

Address: ____________

City, State, ZIP Code: ____________ Phone Number: ____________

IHCP RID Number: ____________ Social Security Number: ____________

Copy of authorization attached: Yes ____ No ____ Date of authorization (if known): ____________

Section B: Description of Authorization Revoked

Do you wish to revoke all of the previous authorization or only part of the previous authorization? Select one of the boxes below and complete all information on this form.

☐ Please revoke the entire previous authorization ☐ Please revoke only part of the authorization

Health Information: Describe the health information, including and the dates of the records that were previously authorized for the use or disclosure by the IHCP:

____

____

____

Person or Organization Authorized to Use or Disclose: Name or specifically identify the persons or organizations, including the IHCP, previously authorized to make use of or disclose the health information described above:

Name: ____________

Address: ____________ Phone Number: ____________

Person or Organization to Receive and Use: Name or specifically describe the persons or organizations who had authorized the IHCP to disclose or let use the health information described above:

Name: ____________

Address: ____________ Phone Number: ____________

Name: ____________

Address: ____________ Phone Number: ____________

(Continued)

Section C: To the member – Please sign the form.

Signature: ______________________________ Date: ______________________________

Section D: To the member's personal representative – Please sign the form and complete the appropriate information

If this request is from a personal representative on behalf of the IHCP member, please provide a copy of the documentation to support the representation and complete the following:

Personal Representative's Name: ______________________________ Date: ____________________

Relationship to IHCP Member: ______________________________

This form must be notarized if submitted by the member's personal representative.

Subscribed and sworn (affirmed) before me this __________ **day of** ______________ **,** __________

Signature: ______________________________

Notary Public in and for the state of ____________________

In the county of ______________________________

(Affix seal) My commission expires: ______________________________