Wellmark Advantage Health Plan

Wellmark Advantage Health Plan, Inc. is an independent licensee of the Blue Cross and Blue Shield Association.

AUTHORIZATION TO REVOKE A PREVIOUS AUTHORIZATION

Use this form to revoke a previous authorization to disclose protected health information.

Section A: Individual revoking authorization – Please complete the following information:

NAME		DAYTIME PHONE NUMBER	
ADDRESS			
CITY	STATE	ZIP	ENROLLEE ID

Section B: Revocation

☐ I revoke my authorization for use and disclosure of my protected health information described in my original authorization (or as described in Section C below).

☐ I revoke my authorization for use and disclose of psychotherapy notes described in my original authorization (or as described in Section C below).

Is a copy of original authorization attached? ☐ Yes ☐ No (Please complete Section C)

I understand that this revocation *will not* affect actions taken in accordance with my original authorization prior to receipt of this written revocation.

Section C: Description of authorization you are revoking (Complete this section if you checked "No" in Section B)

Date of authorization (if known): _____

Describe in detail the persons or entities and the information that the original authorization applied to (person who was authorized to receive protected health information, dates of treatment, type of service, etc.):

☐ **Disclosure by Wellmark Advantage Health Plan:**
I am revoking my authorization for Wellmark Advantage Health Plan to use and disclose the protected health information described above.

☐ **Disclosure by Wellmark Advantage Health Plan:**
The revoked authorization allowed Wellmark Advantage Health Plan to receive and use protected health information described above.

Section D: Signature

_____ _____

Signature *Date*

Section E: Personal representative – If you are not the patient, please sign and date below then check the box that describes your relationship to the member. **If you are not the parent, please attach proof of your relationship to the member (e.g., power of attorney, personal representative documentation, etc.).**

Print name of personal representative: _____

Signature of personal representative and date: _____

☐ Parent of minor child ☐ Legal guardian ☐ Power of attorney ☐ Executor ☐ Other

INSTRUCTIONS FOR
COMPLETING THE REVOCATION
OF AUTHORIZATION

Fill out the form completely. The authorization is not valid unless it is filled out completely.

- This form cannot be used as a joint authorization with another member; therefore, each member must submit a separate form
- Please type or print the information

Section A: Authorization. Please include the following information about the member whose protected health information is being disclosed:

1) Member's first and last name.
2) Member's full street address, including city, state and ZIP code.
3) Include the member's enrollee ID/contract number as it appears on the member's Wellmark Advantage Health Plan ID card.
4) Member's telephone number, including area code.

Section B: Revocation

1) Check yes if you have attached a copy of the original authorization.
2) Check no and complete Section C if you have not attached a copy of your authorization.

Section C: Description of authorization revoked (complete if authorization not attached).

1) Provide the date that the authorization was signed (if known).
2) List in detail the information that the authorization applied to, such as providers, dates of treatment, etc.
3) Check Wellmark Advantage Health Plan was authorized to disclose your protected health information, or if others have been authorized to disclose your protected health information to Wellmark Advantage Health Plan.

Section D: Signature – Members must sign and date the authorization unless the form is completed by their personal representative (see below).

Section E: Personal representative

1) If a personal representative is signing the authorization form on behalf of a member, the representative must sign his or her name and date in the signature line and specify his or her relationship to the member by checking the appropriate box below the signature.
2) The personal representative must print his or her name and relationship to the member and authority to sign. If the personal representative is someone other than the parent of a minor child, written proof is required.

The signer will receive a copy of the completed authorization form via return mail. The original authorization form will be kept on file.

Mailing instructions	Faxing instructions
Please mail completed authorizations to: Wellmark Advantage Member Correspondence PO Box 260040 Plano, Texas 75026	Please fax completed authorizations to: **1-800-456-9517.**

Members who need additional assistance completing this form should call a customer service representative at the number listed on the back of their Blues ID card, or the Blues operator at 1-877-411-6950. TTY users call 711.