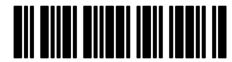

REVOCATION OF AUTHORIZATION TO DISCLOSE HEALTH INFORMATION

I do hereby request that this authorization to disclose health information of 1. ________________________________
(Name of Member and/or dependent)

signed by 2.____ on 3. ______________________________
(Enter Name of Person Who Signed Authorization) *(Enter Date of Signature)*

be rescinded, effective 4.____. I understand that any action taken on this
(Date)

authorization prior to the rescinded date is legal and binding.

5. ____ ________________________________
(Signature of Member, Legal Representative, Spouse or Dependent over 18) **(Date)**

Revocation Instructions

1. Enter the name of the member whose authorization is to be revoked.
2. Enter the name of the person who signed the authorization.
3. Enter the date the authorization was originally signed.
4. Enter the date the authorization is to be revoked.
5. Member, legal representative, spouse or dependent age 18 or over must sign and date the revocation.
6. Return to: **OSEEGIB, 3545 NW 58th, Suite 110, Oklahoma City, Oklahoma 73112**
   ATTN: OSEEGIB HIPAA Privacy Officer