

# REVOCATION OF AUTHORIZATION TO RELEASE INFORMATION

Use this form to revoke an authorization to release information (ARI) previously given to Blue Cross and Blue Shield of Vermont (BCBSVT) and/or The Vermont Health Plan (TVHP).

### Section A: Member Information

Member/Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
Identification Number: \_\_\_\_\_ Telephone: \_\_\_\_\_  
Address: \_\_\_\_\_

### Section B: Statement of revocation

I revoke my previous authorization for your use and/or disclosure of my protected health information as described below.

I understand that this revocation of my authorization will *not* affect any action BCBSVT/TVHP, its subsidiaries, affiliates, employees, officers and agents including, but not limited to, Express Scripts and Magellan Behavioral Health or others took in reliance on my authorization before receipt of this written notice of my revocation.

### Section C: Description of authorization to be revoked

Please attach (if available) a copy of the Authorization to Release Information (ARI) that is being revoked. If a copy of the Authorization to Release Information is not attached, please provide the following information.

Date of authorization (if known): \_\_\_\_/\_\_\_\_/\_\_\_\_

Please provide the name of the person(s) that is no longer authorized to receive your Protected Health Information (this information should match the Authorized Person on the original Authorization to Release Information):

Name: _____	Name: _____
Organization (if applicable): _____	Organization (if applicable): _____
Address: _____	Address: _____
Telephone: _____	Telephone: _____
Relationship to Patient: _____	Relationship to Patient: _____

### Section D: Individual's Signature

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**If you are a personal representative (Parent, Legal Guardian, agent acting under a Durable Power of Attorney for Health Care, or Executor or Administrator of Estate) signing on behalf of the Member/Patient, complete the following:**

Personal Representative's Name: \_\_\_\_\_

Relationship to Individual: \_\_\_\_\_

**Please keep a copy of this document for your records and mail the completed Revocation to Blue Cross and Blue Shield of Vermont, Attn: Privacy Officer, PO Box 186, Montpelier, VT 05601.**



**BlueCross BlueShield  
of Vermont**  
*Independent Licensees of the Blue Cross and Blue Shield Association.*

