



**Authorization to Disclose Health Information  
Revocation Section**

I do hereby request that this authorization to disclose the health information of

\_\_\_\_\_ signed by \_\_\_\_\_  
(Name of Health Plan Member) (Enter Name of Person Who Signed Authorization)

on \_\_\_\_\_ be rescinded effective \_\_\_\_\_.  
(Enter Date of Signature) (Date)

I understand that any action on this authorization prior to the rescinded date is legal and binding.

\_\_\_\_\_  
(Signature of Health Plan Member) (Date)

\_\_\_\_\_  
(Signature of Witness) (Date)

\_\_\_\_\_  
(\*Signature of Personal Representative) (Date) (Personal Representative Relationship/Authority)

\* In order for the need for a Signature of Personal Representative to be used, the Health Plan Member must be incapacitated to the point of being unable to make health related decisions for themselves. If this is Signed, then there must be a Witness Signature (and date) with the Personal Representative Relationship/Authority blank to be completed.