



## Revocation of Authorization to Release Protected Health Information

I, \_\_\_\_\_, hereby revoke the authorization to release information I provided to Independence Administrators that allowed Independence Administrators to use and disclose my Protected Health Information as I outlined on the authorization form, which I signed on \_\_\_\_\_ for release of my Protected Health Information to \_\_\_\_\_. I understand that this revocation does not apply to any action Independence Administrators has taken in reliance on the authorization I signed earlier. This revocation does not revoke any and all previous authorizations to release information that I have provided to Independence Administrators.

\_\_\_\_\_  
Plan Member's name

\_\_\_\_\_  
Date

### SPECIAL PROVISIONS

In this section, the individual should outline any special provisions regarding the revocation of the authorization.

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\_\_\_\_\_  
Plan Member's name

\_\_\_\_\_  
Date



To: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Enclosed is the form you have requested. Please complete and return all pages of the form to our attention:

Independence Administrators  
602 Office Center Drive • Suite 350  
Fort Washington, PA 19034  
Attn: Privacy Official

- Only fully completed forms will be accepted.
- Forms must be typed or legibly written.
- Forms must be signed and dated.

We will begin to process your request on the day it is received. If your request is denied for any reason, you will receive an explanation of the denial.