Revocation of Authorization or Designation of Personal Representative

CareFirst Community Health Plan Maryland

This form is to revoke an authorization or personal representative designation. Completing and submitting this revocation to the CareFirst BlueCross BlueShield Community Health Plan Maryland (CareFirst CHPMD) Privacy Office allows you to rescind your original authorization or personal representative designation.

Please type or print neatly. We will not process incomplete or illegible forms.

Please mail or fax this authorization to: CareFirst CHPMD, Privacy Office, PO Box 14858, Lexington, KY 40512
Fax: 1-410-505-6692

Please keep a copy of this authorization for your records.

STATE OF REVOCATION

Please select the option that fits your need.

- ◯ I hereby revoke **my authorization** for release of protected health information.
- ◯ I hereby revoke **my designation** of a personal representative.

I understand that this revocation will not affect any action that the health plan or health plan administrator took before receiving my written notice of revocation. I also understand that if the authorization was requested to adjudicate payment of a claim on my behalf, my revocation may result in the health plan or health plan administrator refusing payment of the claim.

MEMBER REVOKING THE RELEASE OF INFORMATION

Last Name, First Name, MI			Member ID
Street Address			
City		State	ZIP
Home Telephone	Work Telephone	Date of Birth (mm/dd/yyyy) / /	

AT MY REQUEST, I WANT TO REVOKE THE RELEASE OF MY PROTECTED HEALTH INFORMATION TO

Name of Individual or Organization

Name of Individual or Organization

PLEASE READ EACH OF THE FOLLOWING STATEMENTS CAREFULLY BEFORE SIGNING THIS DOCUMENT

I understand that by signing this form, I am confirming that my health plan or health plan administrator may no longer use and/or disclose my protected health information to the persons and/or organization named in this form.

Signature	Date

Must be the original signature of any person 18 years of age or older whose records have been requested. If this request is made by a personal representative on behalf of the individual, please attach a complete copy of the personal representative form or legal document indicating your legal authority to sign this form.

Any mental health or substance use disorder information, which has been disclosed from medical or other health care records, may be protected by federal and/or state law. If the records are so protected, Federal Regulation (42 CFR Part 2) and/or Washington, D.C. and Maryland mental health laws prohibit the recipient of the information from making any further disclosure of this information unless such disclosure is expressly permitted by the written consent of the person to who it pertains, or as otherwise permitted by 42 CFR Part 2 and/or Washington, D.C. and Maryland mental health laws. 42 CFR Part 2 prohibits unauthorized disclosure of these records.