

Revocation of Authorization for the Release of Protected Health Information (PHI)



Previously, you completed an *Authorization for the Release of Protected Health Information (PHI) Form* allowing Blue Cross and Blue Shield of Kansas (Blue Cross) to share your PHI with a person, category of people, or entity. It is your right to revoke that authorization at any time and for any reason. It is required that Blue Cross receive this request in writing. By completing the fields on this form that apply to you, Blue Cross will no longer share your PHI with the indicated person, category of people, or entity.

Section 1 – Person Authorizing Revocation

_____ First Name	_____ Mailing Address
_____ Last Name	_____ City
_____ Member Identification Number	_____ State
	_____ ZIP Code
	_____ Date of Birth

Section 2 – Revocation Request

- I am revoking the PHI authorization (excluding information pertaining to Substance Abuse) for the person, category of people, or entities listed below.
- I am revoking the PHI authorization for information pertaining to Substance Abuse for the person, category of people, or entities listed below.

_____ First Name or Category (i.e., billing staff, medical staff)	_____ Organization Name
_____ Last Name	

- Dependent Child Revocation (under age 18):** I am revoking the authorization for the release of PHI for my dependent(s) listed below.

_____	_____
_____	_____

Section 3 – Authorization

I understand that by signing this form, PHI will no longer be shared with the person, category of people, or entity identified above. I understand that Blue Cross and Blue Shield of Kansas does not condition payment, enrollment or eligibility for benefits

whether I sign this *Revocation of Authorization for the Release of Protected Health Information*. In addition, I understand that information may have been shared with the above identified party prior to Blue Cross receiving this revocation.

Your signature required

_____ Applicant (Signature of parent/guardian if other than applicant)	_____ Date Signed
_____ Print Name	

When completed, please mail to:
Blue Cross and Blue Shield of Kansas
1133 SW Topeka Blvd., Topeka, KS 66629-0001

Note: Please keep a copy of this form for your files.

Internal Use Only
Return to _____
Mail stop _____