Individual Request for
Revocation of Authorization

PURPOSE: This form is used to revoke or to confirm revocation of an authorization previously given to CenBen, USA, Inc.

SECTION A: Individual Requesting Revocation of Authorization

Covered Employee's Name: ____ Employee's SSN: ________-________-________

Covered Employee's Employer: ____ Current Phone: ________-________-________

Name of Individual Making Request: ____ Individual's SSN: ________-________-________

Current Address: ____

Copy of authorization attached: Date of authorization (if known): _____/ _____/ _____

- ☐ Yes
- ☐ No

SECTION B: Description of Authorization Revoked

Protected Health Information: The revoked authorization had authorized use and/or disclosure of the following protected health information:

____

____

____

Entities Authorized to Use or Disclose: The revoked authorization had authorized the following persons and/or organizations (or classes of persons and/or organizations), including our Company, to make use of and/or to disclose the protected health information described above:

____ ____

____ ____

Entities Authorized to Receive and Use: The revoked authorization had authorized the following persons and/or organizations (or classes of persons and/or organizations) to receive and/or use the protected health information described above:

____ ____

____ ____

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SECTION C: Signatures

I revoke my authorization for the Company's use and disclosure of my protected health information as described below.

I understand that revocation of my authorization will *not* affect any action CenBen USA, Inc. or others took in reliance on my authorization before they received this written notice of my revocation. I also understand that, if my authorization was a condition of my enrollment in the Company's health plan or of my eligibility for benefits, or was protected health information that the Company requested to adjudicate payment of a claim involving me, the Company may disenroll me from the health plan, end my eligibility for the benefits, or not pay the claim.

_______________________________	_______________________________
Patient's Printed Name	Date
_______________________________	_______________________________
Patient's Signature	Date

If this form is signed by a personal representative on behalf of the individual, complete the following:

_______________________________	_______________________________
Patient Representative's Printed Name	Date
_______________________________	_______________________________
Patient Representative's Signature	Date

____

Relationship of Representative to Individual

Please submit this request to HealthSCOPE Benefits at any of the following addresses:

HIPAA Official
P.O. Box 1224
Little Rock, AR 72203
or

Customer Service – HIPAA
PO Box 16526
Columbus, Ohio 43216
or

Customer Service – HIPAA
PO Box 50440
Indianapolis, IN 46250

YOU HAVE THE RIGHT TO RECEIVE A COPY OF THIS FORM