

# Revocation of Authorization for Release of Personal and Health Information



Member Name \_\_\_\_\_ Contract Number \_\_\_\_\_

Address \_\_\_\_\_ City/State/Zip \_\_\_\_\_

Phone Number \_\_\_\_\_ Date of Birth \_\_\_\_\_

I request that Priority Health/Priority Health Managed Benefits, Inc. /Priority Health Insurance Company/Priority Health Government Programs, Inc. (“Priority Health”) revoke the authorization that I have on file with Priority Health that permits:

(Specific Name of Person or Entity) \_\_\_\_\_ to access my personal and health information.

I understand that this form is intended to terminate my previous authorization to release information. I understand that this revocation will be effective three business days after it is received by Priority Health and will not be effective to the extent that Priority Health has already disclosed information to this person/entity. I understand that re-disclosure of any information released prior to this revocation may have already occurred or may occur in the future without my knowledge or consent; therefore, the privacy of my personal and health information may no longer be protected by law.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date Signed

If signed by a person other than the member, please check the relationship and authority to do so:

- Parent of Minor Child
- Power of Attorney
- Legal Guardian
- Personal Representative of Deceased Person
- Member is mentally competent, but physically unable to sign and has verbally asked or physically demonstrated a request for the above signer to sign on the member’s behalf.

Witnessed by: \_\_\_\_\_ Date: \_\_\_\_\_

**Please mail form to:**  
Priority Health, MS:2005; 1231 East Beltline, NE; Grand Rapids, MI 49525-4501  
**or fax to:** 616 942-0616