Revocation of Authorization for the Use and Disclosure of Protected Health Information (PHI)

Complete the following chart with information about the person whose PHI is subject to this Revocation.

Name (Last, First, MI):	
Address (City,State,Zip):	
Phone:	
Date of Birth:	

If you are not the employee, complete the following:

Employee Name:	
Employee ID #:	
Employee Date of Birth:	

I hereby revoke the authorization made on or about _____allowing the Health Plan to use and/or disclose my PHI. I understand that the revocation is only effective after receipt by the Plan's Privacy Official. I also understand that that any use or disclosure prior to the date this Revocation is received by the Privacy Official will not be affected by it.

Please describe the PHI that was previously allowed to be disclosed:

By signing below, I certify that I have read and understand this Revocation of Authorization. If I am a personal representative, I certify and attest that I am the duly authorized representative of the person whose health information is subject to this Revocation of Authorization. *(A personal representative may be requested to provide verification of representative status.)*

_____ _____

Signature of applicant or personal representative **Date**

Relationship of personal representative to member: _____

Send completed form to:
Privacy Official

Human Resources
7575 E. Main Street
Scottsdale, AZ 85251

Phone: (480) 312-7600
FAX: (480) 312-7960