Revocation of Authorization for Release of Health Information

Individual's Full Name	Date of Birth	Member or Subscriber ID #

Individual's Street Address	City	State	Zip Code

By signing this form I wish to exercise my right to revoke an Authorization for Release of Information on file with Optum. I understand this revocation will not affect any action that Optum or its affiliates took before receiving my written request. Additionally, In the event my personal health information has been released by valid authorization this information cannot be retracted. Any information which was released pursuant to a valid authorization may no longer be protected under federal or state law and could be further released by the individual who received the information prior to the revocation request.

Per my request, Optum and its affiliates are to discontinue providing my individually identifiable health information to the following person(s) or organization(s):

(Full Name of Person(s) or Organization(s))

(Full Address of Person(s) or Organization(s))

Signature of Individual	Date

Witness Signature *(For Illinois Residents Only)*	Date

Please note: If you are a guardian or court appointed representative, you must attach a copy of your legal authorization to represent the member.

Signature of Individual's Representative	Date

Personal Representative's:

Name	Phone Number

Street Address	City	State	Zip Code

PLEASE MAINTAIN A COPY OF THIS DOCUMENT FOR YOUR RECORDS