



ASSOCIATED BENEFITS CORPORATION

AUTHORIZATION REVOCATION

Purpose: This form is used to revoke or to confirm revocation of an authorization previously given to us.

SECTION A: Individual revoking the authorization.

Name: _____

Address: _____

Telephone: _____

E-mail: _____

Identification Number: _____

Social Security Number: _____

SECTION B: Statement of revocation.

I revoke my previous authorization for your use and/or disclosure of my protected health information as described below.

I understand that this revocation of my authorization will *not* affect any action you 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 your health plan or of my eligibility for benefits, or was for protected health information that you requested to adjudicate payment of a claim involving me, you may disenroll me from the health plan, end my eligibility for the benefits, or not pay the claim.

Copy of authorization attached: Yes No

SECTION C: Description of authorization revoked (complete if authorization not attached).

Date of authorization (if known): ____/____/____

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

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

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

INDIVIDUAL'S SIGNATURE.

Signature: _____ Date: _____

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

Personal Representative's Name: _____

Relationship to Individual: _____

Send completed and signed form to:

Associated Benefits Corporation
Privacy Office
P.O. Box 71039
Des Moines, IA 50325-0039