illinicare health

Revocation of Authorization to Disclose Health Information

I WANT TO CANCEL, OR REVOKE, THE PERMISSION I GAVE TO ILLINICARE HEALTH TO SHARE MY HEALTH INFORMATION WITH THIS PERSON OR GROUP:

MAIL TO:
IlliniCare Health
Privacy Officer
999 Oakmont Plaze Drive
Suite 400
Westmont, IL 60559

866-329-4701

Recepient Information

Name (person group):	Phone:
Address: City: Zip:	Authorization Signed Date (if known):

Member Information

Member Name (print):	Member Date of Birth:
Member ID Number:	**Member Signature:** **Date:**

I understand that my health information may have already been shared because of the permission I gave before. I also understand that this cancellation only applies to the permission I gave to share my health information with this person or group. It does not cancel any other authorization forms I signed for health information to be shared with another person or group.

If you are signing for the member, describe your relationship below. If you are the member's personal representative, describe this below and send us copies of those forms (such as power of attorney or order of guardianship):

_____

IlliniCare Health will stop sharing your health information when we get this form. Use the mailing address above. You can also call for help at the number below.