Revocation of Authorization to Release Protected Health Information

REVOCATION OF AUTHORIZATION TO RELEASE INFORMATION

I, _____, hereby revoke the authorization to release information I provided to AmeriHealth Administrators that allowed AmeriHealth Administrators to use and disclose my Protected Health Information as I outlined on the authorization form, which I signed on _____ for release of my Protected Health Information to_____. I understand that this revocation does not apply to any action AmeriHealth Administrators has taken in reliance on the authorization I signed earlier.

This revocation does not revoke any and all previous authorizations to release information that I have provided to AmeriHealth Administrators.

Participant's name Date

SPECIAL PROVISIONS

In this section, the individual should outline any special provisions regarding the revocation of the authorization.

Participant's name Date

To: _____
_____
_____

Enclosed is the form you have requested. Please complete and return all pages of the form to our attention:

AmeriHealth Administrators
Attn: Privacy Official
1900 Market Street, Suite 500
Philadelphia, PA 19103

Only fully completed forms will be accepted.
Forms must be typed or legibly written.
Forms must be signed and dated.

We will begin to process your request on the day it is received. If your request is denied for any reason, you will receive an explanation of the denial.