



Protected Health Information Authorization Cancellation Form

Want to cancel your authorization to share your protected health information? Just complete and return this form. When you do, we'll stop sharing your protected health information (PHI) with those people and corporations to whom you authorized us to communicate. Please be sure to include the names of each person with whom you had previously authorized us to share information. Additional copies of this form can be found on our Web site at: www.univeracommunityhealth.org. Please complete all steps to cancel your authorization.

Step One:

I wish to revoke my authorization permitting Univera Community Health to release my protected health information to the following person, persons or organizations:

Name: _____

Name: _____

Name: _____

Step Two:

Member ID Number: _____

I wish to cancel my authorization permitting Univera Community Health to release my protected health information to those listed in Step One above effective: Month: _____ Day: _____ Year: _____

I, (please print name here) _____, have had full opportunity to read and consider the contents of this authorization revocation form. I understand that, by signing this form, I confirm that the information contained on this document is correct. I also understand that the revocation of this authorization will not take effect until Univera Community Health receives my authorization cancellation form.

I understand that I may refuse to sign this form, however, without my signature, Univera Community Health cannot process my cancellation request.

Signature: _____ **Date:** _____

(Member or Personal Representative)

If this request is by a personal representative on behalf of our member, please give us the following information:

Personal Representative's Name: *(please print)* _____

Description of Personal Representative's Authority (a power of attorney, legal guardian or state executor):

Please note: personal representatives must provide legal proof of representation, such as power of attorney documentation, if not sent previously.

Step Three:

Please return the completed form to:

Univera Community Health
C/O Univera Health Care
P.O. Box 4839
Syracuse, NY 13221
FAX: 1-315-671-7079

PLEASE MAKE A COPY OF THIS FORM FOR YOUR RECORDS