Blue Cross Blue Shield of Michigan
Blue Care Network of Michigan
BCN Service Company
BlueCaid of Michigan

AUTHORIZATION REVOCATION

USE THIS FORM TO REVOKE AN AUTHORIZATION PREVIOUSLY GIVEN.

Section A: Individual revoking authorization

Please complete the following information:

NAME			DAYTIME PHONE NUMBER
ADDRESS			
CITY	STATE	ZIP	CONTRACT NUMBER

Section B: Revocation

I revoke my authorization for use and disclosure of my protected health information (PHI) described in my original authorization (or as described in Section C below).

Is a copy of original authorization attached? ☐ Yes ☐ No (Please complete Section C.)

I understand that this revocation *will not* affect actions taken in accordance with my original authorization prior to receipt of this written revocation.

Section C: Description of authorization you are revoking (Please complete or attach a copy of original authorization)

Date of authorization (if known): _____

Describe in detail the persons or entities and information that the original authorization applied to (dates of treatment, type of service, etc.):

☐ **Disclosure by BCBSM, BCN, BCN SC, BCMI or BlueCaid of MI:**
I am revoking my authorization for BCBSM, BCN, BCN SC, BCMI or BlueCaid of MI (please circle one) to use and disclose the PHI described above.

☐ **Disclosure to BCBSM, BCN, BCN SC, BCMI or BlueCaid of MI:**
The revoked authorization allowed BCBSM, BCN, BCN SC, BCMI or BlueCaid of MI (please circle one) to receive and use PHI described above.

Section D: Signature

COMPLETED

_____ _____
Signature Date

If you are not the member, please sign and write today's date below, then check the box that describes your relationship to the member. If you are not the parent of the member, please attach proof of your relationship to the member.

Print Name of Personal Representative: _____

_____ _____
Signature of Personal Representative Date

☐ Parent of minor child ☐ Legal Guardian ☐ Power of Attorney ☐ Executor ☐ Other _____

Mailing Instructions

Mail your completed form to the BCBSM, BCN, BCN SC, BCMI or BlueCaid of MI team to whom you mailed your original authorization. If you are unsure of the mailing address, call your customer service representative at the phone number on the back of your Blues ID card, or call the Blues operator at 313-225-9000. **WE WILL MAIL A COPY OF THIS SIGNED REVOCATION TO YOU**

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INSTRUCTIONS FOR COMPLETING THE REVOCATION OF AUTHORIZATION

Section A - <u>Individual revoking authorization</u>

1) Member's first and last name
2) Member's full street address, including city, state and ZIP code
3) Subscriber's contract number as it appears on the BCBSM, BCN, BCN SC, BCMI or BlueCaid of MI ID card
4) Member's phone number, including area code

Section B – <u>Revocation</u>

1) Check yes if you have attached a copy of the original authorization.
2) Check no and complete Section C if you have not attached a copy of your authorization.

Section C – <u>Description of authorization revoked (complete if authorization not attached).</u>

1) Provide the date that the authorization was signed (if known)
2) List in detail the information that the authorization applied to, such as providers, dates of treatment, etc.
3) Check if BCBSM, BCN, BCN SC, BCMI or BlueCaid of MI was authorized to disclose your PHI, or if others have been authorized to disclose your PHI to BCBSM, BCN, BCN SC, BCMI or BlueCaid of MI.

Section D <u>Signature</u>

1) The member is required to sign and date the authorization revocation. If the individual that signs the form is a personal representative, the individual must specify his or her relationship to the member.
2) The personal representative must print his/her name and detail relationship to the member and authority to sign. If the personal representative is someone other than the parent of a minor child, written proof is required.

Members receive a copy of their completed revocation forms. The original authorization form and this revocation are kept on file by the operating unit that processed the authorization.

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