Health Partners Plans

Revocation/Cancellation Request

Use this form to request a change or revocation to a previously approved Request for Restriction, Request for Alternative Communications or Authorization.

INSTRUCTIONS FOR COMPLETING THIS REVOCATION/CANCELLATION FORM

Part 1: Member information. This section should name the Health Partners Plans (HPP) member requesting a cancellation of an authorization. Print the member's name, birth date, address, telephone number, and Member ID number.

Part 2: Information to be cancelled. Provide information about the authorization you would like to cancel.

Part 3: Review and approval. The *member's* signature is required. If the member is incapable of signing, a personal representative may sign on the member's behalf. Parents or guardians of minors will be confirmed using information from the state. A personal representative (PR) such as an executor or someone with power of attorney may sign his or her name in the member's place. The legal documents proving the authority of the personal representative to act for the member **MUST** be attached or on file at HPP; otherwise, the PR's signature will be invalid, and this form will **NOT** be processed.

Complete ALL sections. If information on this form is not complete, Health Partners Plans will return the form and will not consider this request until it has received complete information.

CONTACT INFORMATION

RETURN YOUR CANCELLATION/REVOCATION FORM(S) TO THE ADDRESS LISTED BELOW

If you have any questions or need assistance in completing this form, call the Member Relations telephone number on the back of your identification card or write to:

Health Partners Plans
Privacy Services
1101 Market Street, Suite 3000
Philadelphia, PA 19107
or
Fax: 267-515-6666

Revocation/Cancellation Request

All fields are required.

Part 1: Please PRINT the requested information below

Member Name:	Date of Birth:
Address:	City/ZIP:
Member ID #:	Telephone:

Part 2: Information to be revoked/cancelled

I hereby request that Health Partners Plans cancel or revoke the following. ***(Check all boxes that apply.)***

☐ All authorizations to release my protected health information to any third party.
☐ All restrictions requests of my protected health information to any third party.
☐ Specific authorization dated ____/____/____ that authorized Health Partners Plans to release/disclose information to:

Person's or organization Name: Relationship to Member:

Address: Telephone:

Fax:

☐ Specific restriction dated ____/____/____ that restricted Health Partners Plans to release/disclose information to:

Person's or organization Name: Relationship to Member:

Address: Telephone:

Fax:

Part 3: Signature

I understand that this revocation request will not affect any actions that Health Partners Plans took before it received this revocation form.

I have read and understand the above information:

Member or personal representative name (please print): _____.

Signature: _____ Date:_____.

If you are a personal representative, state your relationship to the member:_____.

Note that, if not already provided, we will require verification of the authority of a personal representative such as a copy of a health care, general or durable power of attorney before this request will be considered complete.

If this request is made by a parent/guardian, complete the following:
Member/participant is a minor ____ years of age*. If you are making this request on behalf of a minor child, we may require additional information such as a court order or other documentations that shows custody or other legal document showing the authority of the legal representative to act on the member's behalf before this request is considered complete.*