wellcare™

Revocation of Authorization to Release Protected Health Information (PHI) and Records

Purpose to Revoke Authorization:
I revoke all or part of my previous authorization for the health plan to use and disclose my health information. I have marked the details below.

I understand that this revocation of my authorization will *not* affect any action WellCare or others took on my authorization before this written notice was received.

Member Information:

Print Member Name: _____. DOB (mm/dd/yyyy): _____

Address: _____.

Telephone Number: _____. Member ID Number:_____.

Medicare Number: _____. Medicaid Number:_____.

Copy of Previous Authorization Form Attached:

- ☐ Yes
- ☐ No (complete below section)

Authorization Revoked:

By signing this form, I agree that the health plan will revoke my authorization with the person named below on this form.

Check the items of information that you want revoked. This would be the information that you asked to have released to the person you have named to act for you.

- ☐ Psychotherapy notes. (**Please note**: If you check this box, you may not check other boxes. You must fill out an *Authorization to Release Health Information and Records* to get other types of records.)
- ☐ Entire health record (includes all options below)
- ☐ Appeals and grievances
- ☐ Claims history
- ☐ Diagnoses and/or treatment for alcohol and/or drug abuse
- ☐ Diagnoses and/or treatment of AIDS, AIDS Related Complex (ARC), HIV, or other communicable diseases

☐ Other: _____

_____

_____

Representative Information:

Print Name of Representative: _____ DOB (mm/dd/yyyy): _____

Address: _____

Telephone Number: _____

Relationship to Member: _____

Effective Date of Revocation:
This revocation of authorization to use or disclose protected health information is in effect as of
_____/_____/_____
mm dd yyyy

Acknowledgment:

I understand:

- Submitting a revocation form will not revoke any other authorizations to release information that I have provided to the health plan. Revocation of this authorization will not affect any action that the health plan has taken, or any PHI that the plan has already released.
- I have the right to get a copy of this form after it has been signed.

_____
Signature of Member

_____
Print name of Member

_____
Date

- If you are signing for the member as his or her representative, please sign below. A POA must be on file with Wellcare Dual Liberty (HMO D-SNP).

_____
Signature of Personal Representative

_____
Print name of Personal Representative

_____
Relationship to Member

_____
Date

Please return this form or your request to revoke authorization to:

Wellcare Dual Liberty (HMO D-SNP)

Attn: Enrollment Department – CCP

PO Box 31378, Tampa FL 33631

Fax: 1-866-473-9124