



## Cancel Sharing My Information

To Revoke Authorization to Use or Disclose Sensitive Health Information

On \_\_\_\_/\_\_\_\_/\_\_\_\_ (Month/Day/Year), I signed an Authorization to release health information to:

---

---

I hereby revoke such Authorization effective immediately. I understand that the health information may already have been disclosed pursuant to and in reliance on my prior Authorization. I also understand that this revocation applies only to the information specifically described in the above-referenced document, and does not affect any prior executed Authorizations for other information.

If this revocation is limited (for example, you want us to stop disclosing some but not all of the information described above), please describe the limitations in the area below. If you leave this part blank, we will treat the revocation as complete.

**Limitations/Conditions:**

---

---

---

Signature of Member or Legal Representative

---

Date

---

Print Name

If signing on behalf of a member, please describe your authority and provide related documentation:

---

---

Your revocation will be effective once it is received at the following address:

Louisiana Healthcare Connections  
ATTN: Privacy Officer  
8585 Archives Avenue, Suite 310  
Baton Rouge, LA 70809