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
P.O. Box 84180
Baton Rouge, LA 70884