Revocation of HIPAA* General Authorization for Disclosure of Protected Health Information (PHI)/Electronic Protected Health Information (ePHI)

Health Insurance Portability and Accountability Act of 1996

St. Louis – Kansas City Carpenters Regional Health Plan (Plan)
1419 Hampton Avenue, St. Louis, MO 63139
Phone: (314) 644-4802 | Toll-Free: (877) 232-3863 | Fax: (314) 678-1110 | Email: benefits@laborfunds.org

This form revokes or terminates permission to disclose PHI/ePHI to a previously authorized Person or Entity.

A. Covered Individual terminating authorization to disclose protected health information – Please PRINT:

Covered Individual Last Name	Covered Individual First Name	Cov Ind Middle Name

Date of Birth	Last 4 Covered Individual SSN	Best Contact Phone Number

B. Revocation of Authorization – Please PRINT:

I revoke any authorizations I have previously given to the Plan to disclose my protected health information to the following Person or Entity.

Full Name of Person or Entity previously authorized to receive PHI/ePHI:	Relationship	Phone Number
Full Name of Person or Entity previously authorized to receive PHI/ePHI:	Relationship	Phone Number

The Plan may no longer disclose the following PHI/ePHI to the Person/Entity listed above (choose all that apply):

☐ Entire Medical Record ☐ Mental/Behavioral Health Information, excludes Psychotherapy Notes

☐ Genetic Information ☐ Other, please list: _____

Important Information Concerning Covered Individual Rights

1. The Covered Individual is the participant or dependent covered under the St. Louis-Kansas City Carpenters Regional Health Plan.
2. The Covered Individual's signature on this form will not affect your treatment, payment, enrollment in health plan or eligibility for benefits.
3. Upon request, a copy of this signed Authorization will be sent to the Covered Individual listed in Section A.
4. If signed by a legally authorized Personal Representative (Power of Attorney, etc.), legal documentation must be attached.
5. Any revocation will not apply to any action that the Plan may have already taken on the Covered Individual's behalf before receipt of the signed Revocation of HIPAA Authorization Form.

C. Covered Individual's Signed Revocation:

By completing and signing this form, I understand and agree I am now revoking my prior HIPAA Authorization to release my PHI/ePHI to the person or entity listed above. I also understand that this revocation will not affect any action the Plan may have already taken in reliance on my authorization before they receive this written notice.

_____ _____

Covered Individual Signature **Date**

(Signature of Parent if Covered Individual is a minor under the age of 18) or (Legal Personal Representative, see #7 above)

_____ _____

Legal Personal Representative's Name – please print *(if applicable)* **Personal Representative's Phone Number**

For office use only