AUTHORIZATION REVOCATION

(Note: If the form is not complete, signed, and dated, it becomes invalid and cannot be accepted.)

Section 1: Statement of Revocation

I hereby revoke my authorization of the use and/or disclosure of my Protected Health Information as described in the attached authorization. I understand that revocation of this authorization will not affect any action that my Health Plan, or others named or unnamed below, took before my Health Plan received this written notice of revocation. I also understand that if the authorization was requested to adjudicate payment of a claim on my behalf, the Health Plan may refuse payment of the claim.

Last Name: _____ **First Name:** _____ **MI:** ___

If not the employee: _____ **Name of Employee:** _____

Relationship: _____

Last Name: _____ **First Name:** _____

Street Address: _____**Apt #**: _____

City: _____**State:** _____**Zip:**_____

Phone: (home) _____ **(work)** _____

Member #: _____ **Date of Birth:** ____/____/_____

Section 2: Description of Authorization Revoked (Please Print or Type):

Loyola University New Orleans Employee Benefit Plan is authorized to discontinue disclosing certain PHI to the person/entity as described below.

Persons/Organizations Receiving the Information
(Be Specific): Name or specifically identify the person/entity you are revoking the authorization to disclose (release) information to:

_____
_____

Protected Health Information to be revoked from use/disclosure: Specifically describe, in the space provided, the health information you are revoking from use and/or disclose; OR select from the options shown below:

_____
_____

(1) Claims Information, including payment status, procedure/service and/or condition (select those that apply):

_____ ALL
_____ Medical
_____ Dental
_____ Vision
_____ Prescription
_____ Mental Health
_____ Substance Abuse
_____ Other

(2) Information related only to this procedure/service or condition: (e.g. Heart Surgery or Pregnancy, etc.)_____

Section 3: Signature

I, _____, have had full opportunity to read and consider the contents of this revocation, and I confirm that the contents are consistent with my direction to Loyola University New Orleans Employee Benefit Plan. I understand that, by signing this form, I am confirming Loyola University New Orleans Employee Benefit Plan may no longer use and/or disclose the protected health information described above to the persons and/or organizations named in this form.

Signature:_____Date:_____

If a personal representative signs this revocation on behalf of the Individual, complete the following:

Personal Representative's Name: _____

Relationship to Individual: _____

Check One:

☐ **Loyola University New Orleans Employee Benefit Plan has a copy of my authorizing documentation as a personal representative.**

☐ **Attached is a copy of my documentation as a personal representative.**

Please mail or fax the completed Authorization Revocation Form to: Donna Rochon, Privacy Officer for the Loyola University New Orleans Employee Benefit Plan, Human Resources Department, Loyola University New Orleans, 6363 St. Charles Avenue, Campus Box 16, New Orleans, LA 70118, 504.864.7272 (phone), 504.864.7100 (fax).

PLEASE ATTACH A COPY OF THE APPLICABLE PERSONAL REPRESENTATIVE AUTHORIZING DOCUMENTATION AND RETAIN A COPY OF THIS DOCUMENT FOR YOUR RECORDS.