

Revocation of Authorization for Release of Health Information/Person-Centered Service Plan

Member's Full Name	×		
Member's Date of Bi	rth:		
Member's Medicaid I	ID #:		
Member/Family's em	nail:		
Member/Family's ph	one:		
Date of Current Pers	on-Centered Se	ervice Plan:	
Name of Targeted C	are Coordinator	:	
request of my person	onal represent <i>a</i>	ation of release at mative (e.g. if applicable or the followertains to the followertains the followertains to the followertains the	

I understand that this revocation does not apply to any action punder my prior authorization.	oreviously taken
End Date of Access:	
Signature of Participant	Date
Signature of Parent/Guardian/Legal Representative	Date
Please note: If you are a guardian or court appointed representati a copy of your legal authorization to represent the member.	ve, you must attach
PLEASE MAINTAIN A COPY OF THIS DOCUMENT FOR YOUR F	RECORDS