Revocation of Authorization for the Use and Disclosure of Protected Health Information

Member Information
(Individual whose information cannot be revealed)

Name: _____ Date of Birth: ____/____/_____
(Print Name) **Month Day Year**
Address: _____ Phone Number: ( ) ____-_____

_____ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___
(Number that appears in your member ID)
City: _____ Zip Code: _____

I hereby authorize MMM Multi Health to cancel the authorization to disclose protected health information to the following person or entity:

_____.
(Insert the name of the person previously authorized)

This cancellation of the authorization is effective on ____/____/____
Month / Day / Year

_____ _____
Member or Legal Representative Signature Date

I understand that this request to revoke my Authorization does not apply to disclosures already made by the plan. I understand that disclosures of protected health information may be required by law, in some circumstances. For example: domestic violence, national security, report of contagious diseases, among others.

If this authorization is singed by the assigned legal representative, please provide evidence of legal representation as required by state law. (e.g. Power of Attorney, Legal Guardianship).

Once you complete this cancelation, please send it to Customer Service of MMM Multi Health by mail to the postal address that appears in the header of the document or deliver it to any of our regional offices.

PO Box 72010
San Juan PR 00936-7710