# Revocation of Authorization

**Read this information first**

You should complete this form if you wish to revoke (cancel) the authorization for ValueOptions to use or disclose your medical information to your personal or designated representative. This revocation will be effective immediately upon receipt of this completed form to ValueOptions.

*****Mail this form to:**

## Step 1: Complete the demographic information for the person receiving services:

**1.** ________________________________________ **2.** __ __ / __ __ / __ __ __ __
**Name** **Date of Birth**

**3.** ________________________________________ **4.** (__ __ __) __ __ __ - __ __ __ __
**Address** **Home Phone Number**

**5.** ________________________________________ **6.** ____________________________
**Subscriber Name** **Subscriber Number**

## Step 2: Tell us who you are withdrawing authorization to use or receive your medical information:

**7.** ________________________________________________________________
Name of Authorized Representative

**8.** ________________________________________________________________
Address of Authorized Representative

**Step 3: Complete and sign for alcohol and/or drug abuse records authorization to be revoked:**

**I DO NOT AUTHORIZE THE RELEASE OF CONFIDENTIAL INFORMATION RELATING TO DRUG AND/OR ALCOHOL ABUSE.**

**9.** ______________________________________ ___ ___/ ___ ___/ ___ ___ ___ ___
Person receiving services and/or Month Day Year

**10.** ______________________________________ ___ ___ / ___ ___ / ___ ___ ___ ___
Parent/Guardian Signature (if required by State Law) Month Day Year

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**Step 4: Complete your acknowledgement that You understand that:**

- By completing this revocation form, the person listed will no longer have access to your protected health information;
- Revoking this authorization will not affect your benefits, claim payments or care delivered under your benefit plan;
- You have a right to receive a copy of this signed revocation form; and
- The confidential communications between a patient and a licensed psychologist remains intact. (For New Jersey residents only)

**11.** ______________________________________________________ ____________________
Person receiving services signature Date