



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 persons who may or may not directly be involved in making decisions regarding your health care. 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. ____ - ____ - _____ |
| Name of Policy Holder | Policy Holder SS# |

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

7. _____
Name of Authorized person
8. _____
Address of Authorized person

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

