OHIO BENEFIT ADMINISTRATORS

AUTHORIZATION REVOCATION NOTICE

I hereby revoke my Authorization to Disclose Health Information.

Person/organization who was authorized to receive the information: ________________________

I understand Ohio Benefit Administrators will disclose my medical information when required to do so by federal, state, or local law, and that there is no provision to revoke under these circumstances.

I understand that the revocation will not apply to information that has already been released in response to the authorization.

I understand that if the person or entity that received the information is not a health care provider or health plan covered by federal privacy regulations, the information could be re-disclosed by such person or entity and will likely no longer be protected by the federal privacy regulations.

Signature of Member or Legally Authorized Representative __________________________

Date _________

Relationship to Member _______________________

Witness ___________________________

Office Use Only

Date received ______________________

Signature__________________________Title_____________________________

Date ____________