STATE OF LOUISIANA
DIVISION OF ADMINISTRATION
OFFICE OF GROUP BENEFITS

REVOCATION OF AUTHORIZATION FOR USE OR DISCLOSURE OF HEALTH INFORMATION

I hereby revoke authorization to the Office of Group Benefits to use or disclose my health information, as follows:

Health plan member/dependent name: _____

Date of Birth: _____

Address: _____

Telephone: _____
(primary number) *(alternate number)*

Member ID number: _____

Covering the period(s) of health care:

From: (date) To (date)

Information subject to the revocation:

I understand that uses and disclosures of my health information may have already occurred in reliance upon my previously issued authorization and that this revocation does not apply retroactively.

The Office of Group Benefits and its workforce members and officers are hereby released from any legal responsibility or liability for any use or disclosure that occurred in reliance on my previous authorization.

Signature of Health Plan Member/Dependent or Representative Date

Signature of Witness Date

Printed name of health plan member/dependent's representative

Relationship to health plan member/dependent