MUNICIPAL HEALTH
P.O. BOX 188
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MUNICIPAL HEALTH

REVOCATION OF AUTHORIZATION TO DISCLOSE HEALTH INFORMATION

Name of Policy Holder: _____ ID#/SSN: _____

Address: _____

Group/Employer Name: _____

I _____, hereby revoke any and all authorizations to release health information to:

_____/_____
Print Name Relationship to Member

I understand this revocation will not apply to information already released in response to the Authorization to Disclose Health Information previously submitted. I also understand this revocation does not apply to the Program or their lawyers when the law provides the Program the right to contest a claim incurred while I was a covered member under the Program.

Signature: _____ Date: _____

Witnessed by: _____ Date: _____

_____
Print Name