Optum Business area/system: Optum Idaho

Revocation of Authorization for Release of Health Information/Person-Centered Service Plan

Member's Full Name:

Member's Date of Birth:

Member's Medicaid ID #:

Member/Family's email:

Member/Family's phone:

Date of Current Person-Centered Service Plan:

Name of Targeted Care Coordinator:

Revocation:
I hereby revoke my prior authorization of release at my request and/or at the request of my personal representative (e.g. if applicable under state law, parent(s) or legal guardian), as it pertains to the following person(s) or organization(s):

First & Last Name*/ Organization	Phone*	Email*	Role

*Required fields

I understand that this revocation does not apply to any action previously taken under my prior authorization.

End Date of Access: _____

Signature of Participant **Date**

Signature of Parent/Guardian/Legal Representative **Date**

Please note: If you are a guardian or court appointed representative, you must attach a copy of your legal authorization to represent the member.

PLEASE MAINTAIN A COPY OF THIS DOCUMENT FOR YOUR RECORDS