



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