Interoperability Revocation of Authorization Form

CareFirst Community Health Plan Maryland

This form is to revoke (cancel) an authorization (permission). Completing and submitting this form allows CareFirst BlueCross BlueShield Community Health Plan Maryland (CareFirst CHPMD) to rescind (cancel) our original authorization (permission).

YOU MUST COMPLETE THE FOLLOWING		
Enrollee Last Name	First Name	MI
Date of Birth (mm/dd/yyyy) / /	Medicaid Number	
Address		
Address		
City	State	Zip
Phone ( )		

By signing below, I understand that this revocation (cancellation) will not affect any action that the health plan or health plan administrator took before completing this revocation (cancellation). Please submit all written requests to the address below:

CareFirst CHPMD, Inc. Privacy Office, PO BOX 14858, Lexington, KY 40512
Fax: 410-505-6692 Email: privacy.office@carefirst.com

ACKNOWLEDGMENT

By signing below, I understand I am confirming that my health plan or health plan administrator may no longer disclose or share my protected health information to:

If this request is made by a personal representative on behalf of the individual, CareFirst CHPMD may need to collect more information from me before processing my request.

If I change my Personal Representative or I need to modify or change the types of information I previously authorized or permitted my Personal Representative to access, I understand that I will be required to complete a new HIPAA Authorization Form.

I read and considered the contents of this authorization (permission). I understand that, by signing below, I am confirming my authorization (permission) for the disclosures or sharing of information, as described above.

Please indicate the basis of your status as a personal representative:

○ Parent or guardian of a minor ○ Active health care power of attorney ○ Court ordered guardianship of person

ACKNOWLEDGMENT (CONTINUED)

Please provide the following Personal Representative information:

Name		
Email Address	Phone Number	
Address		
Address		
City	State	Zip

Enrollee Name	Date
Signature	Date

Enrollees: Your authorization or permission will be revoked or cancelled upon the successful submission of this form.

Personal Representatives: Your authorization or permission will be revoked or cancelled based upon the completion of the review of additional documentation (documents).