Revocation of Authorization to Disclose Health Information

I want to cancel, or revoke, the permission I gave to **Iowa Total Care** to share my health information with this person or group:

Recipient Information:

Name (person or group): _____

Address: _____

City: _____ State: _____ Zip: _____ Phone: (____) ____ - _____

Authorization Signed Date (if known): _____/_____/_____

Member Information:

Member Name (print): _____

Member Date of Birth: ____/____/_____ Member Medicaid ID Number: _____

I understand that my health information may have already been shared because of the permission I gave before. I also understand that this cancellation only applies to the permission I gave to share my health information with this person or group. It does not cancel any other authorization forms I signed for health information to be shared with another person or group.

Member Signature: _____ **Date**: ____/____/_____
(Member or Legal Representative Sign Here)

If you are signing for the Member, describe your relationship below. If you are the Member's personal representative, describe this below and send us copies of those forms (such as power of attorney or order of guardianship).

_____

Iowa Total Care will stop sharing your health information when we get this form. Please use the mailing address below. You can also call for help at the number below.

Mail To: *Iowa Total Care Quality Improvement Department: 1080 Jordan Creek Parkway, Suite 100 South, West Des Moines, IA 50266 1-833-404-1061 TTY: 711 Fax: 1-833-809-3868*