BlueCross BlueShield Nebraska

PO Box 3248 • Omaha, NE 68180-0001

Member ID: _____

Sub. Last Name: _____

Acronym: ARE

BLUE CROSS AND BLUE SHIELD OF NEBRASKA OFFICE USE ONLY

AUTHORIZATION REVOCATION

This form is used to revoke your previous authorization to release protected health information (PHI). Upon receipt of this form, Blue Cross and Blue Shield of Nebraska (BCBSNE) will no longer release your PHI to the person(s) or organization(s) listed below.

SECTION A: Individual Revoking the Authorization

YOUR NAME: _____

YOUR MEMBER ID NUMBER (AS SHOWN ON YOUR BCBSNE ID CARD)

☐☐☐ ☐☐☐☐☐☐☐☐☐

(PREFIX) (NUMBERS)

YOUR PHONE NUMBER: (Day) _____

(Evening) _____

YOUR ADDRESS: _____ _____

Street Apartment #

_____ _____ _____

City State ZIP Code

SECTION B: Statement of Revocation

I hereby revoke my previous authorization for BCBSNE to release my protected health information (PHI) as described below. I understand this revocation will not affect any action BCBSNE or others took in reliance on my authorization before receiving this written notice of my revocation. I also understand that if my authorization was a condition of my enrollment in a BCBSNE health plan or of my eligibility of benefits, or was for PHI that BCBSNE requested to adjudicate payment of a claim involving me, BCBSNE may disenroll me from the health plan, end my eligibility for the benefits, or not pay the claim.

Copy of original authorization attached: ☐ YES ☐ NO

Date of original authorization (if known): _____

SECTION C: Description of Revoked Authorization (complete only if original authorization is not attached)

Please tell us the name(s) of the person(s) and/or organization(s) who should no longer receive your PHI by completing the table(s) below. Use **TABLE 1** to revoke the authorization of family members or other individuals to receive your PHI. Use **TABLE 2** to revoke the authorization of organizations or Group Health Plan Representatives to receive your PHI.

TABLE 1: Family Members or Other Individuals to be Revoked and No Longer Authorized to Receive Your PHI

Name of Person	Person's Relationship To You	Address	ZIP Code	Telephone Number	Effective Date of Revocation

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TABLE 1: Organizations or Group Health Plan Representatives to be Revoked and No Longer Authorized To Receive Your PHI

Organization	Name of Contact Person	Address	ZIP Code	Telephone Number	Effective Date of Revocation

SECTION D: Your signature

Signature of Individual: _____ Date: _____

If this authorization is signed by a personal representative on behalf of the individual, please complete the following:

Personal Representative Name: _____

Relationship to the member (check one of the following):

☐ **Parent:** As the parent of the minor child you are authorized to obtain protected health information (PHI). If you want to authorize another person to receive PHI on this minor child you must check this box and write your name in the personal representative field above.

☐ **Legal Guardian, Conservator or Executor:** Please attach legal documentation showing that you are the legal guardian, conservator or executor.

☐ **Durable Power of Attorney:** Please attach legal documentation showing that you hold a Durable Power of Attorney.

Please return the completed and signed form in the enclosed postage-paid envelope, OR to the following address:

Blue Cross and Blue Shield of Nebraska
Attention: Privacy Office
P.O. Box 3248
Omaha, NE 68180-0001

Fax Number: 402-392-4153

E-mail: ContactUs@NebraskaBlue.com (scan signed document to e-mail)

If you have questions, need additional information or assistance in completing this form, please contact us at the above address or Toll Free at 877-258-3888.