NEBRASKA

An Independent Licensee of the
Blue Cross and Blue Shield Association

P.O. Box 3248 • Omaha, NE 68180-0001

AUTHORIZATION REVOCATION

ID:

Sub. Last Name:

Acronym: ARE

BLUE CROSS AND BLUE SHIELD OF NEBRASKA OFFICE USE ONLY

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 TELEPHONE NUMBER: (Day) _____ (Evening) _____

YOUR MEMBER ID NUMBER (AS SHOWN ON YOUR BCBSNE I.D. CARD)

(ALPHA PREFIX) (NUMBERS)

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

NEBRASKA

An Independent Licensee of the
Blue Cross and Blue Shield Association

P.O. Box 3248 • Omaha, NE 68180-0001

AUTHORIZATION REVOCATION

BLUE CROSS AND BLUE SHIELD OF NEBRASKA OFFICE USE ONLY

TABLE 2: 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 revocation is signed by a personal representative on behalf of an individual, please complete the following:

Personal Representative's Name: _____

Relationship to the individual (check one of the following): ❑ Parent ❑ Legal Guardian* ❑ Holder of Power of Attorney*
* Please attach legal documentation if you are the Legal Guardian or Holder of Power of Attorney

**Please return 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**

**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**