Revocation Of Authorization

(For AHCCCS members who want to revoke their previously submitted authorization to release health information)

Name:	AHCCCS ID Number or ACN:
Date of Request:	Date of Birth:

I hereby wish to revoke the authorization to release information I provided to AHCCCS that allowed AHCCCS to use and disclose my protected health information as I outlined on the authorization form. I understand that this revocation does not apply to any information already released while the authorization form I signed earlier was valid and in effect.

Please choose one or all that apply to your request:

- ☐ Revoke my *Authorization for AHCCCS to Disclose Protected Health Information* I originally submitted to AHCCCS on ____/____/____
- ☐ Revoke my *Authorization for AHCCCS to Disclose Psychotherapy Notes* I originally submitted to AHCCCS on ____/____/____
- ☐ Revoke my *Authorization to Disclose Protected Health Information to AHCCCS* I originally submitted to AHCCCS on ____/____/____
- ☐ Revoke my *Authorization to Disclose Psychotherapy Notes to AHCCCS* I originally submitted to AHCCCS on ____/____/____
- ☐ Please revoke *ANY and ALL* authorizations previously submitted to the AHCCCS Administration.

In this section, please describe in detail any special provisions regarding the revocation of this authorization. If there are none, indicate "none".

Name: _____

Signature: _____

Received by:

AHCCCS Representative: _____ Date Received: _____