REVOCATION OF AUTHORIZATION TO DISCLOSE HEALTH INFORMATION

I want to cancel, or revoke, the permission I gave to Nebraska 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:

Name (print):_____

Date of Birth: ____/____/____ Member 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).

_____

Nebraska Total Care will stop sharing your health information when we get this form. Use the mailing address below.

Mail To: Nebraska Total Care
Attn: Privacy Officer
2525 N. 117th Ave., Suite 100
Omaha, NE, 68164

Phone: 1-844-385-2192,
Nebraska Relay Service 711