## Form F2: Revocation of Authorization to Release Information

Use this form to revoke an Authorization to Release Information (ARI) previously given to Blue Cross and Blue Shield of Vermont (BCBSVT) and/or The Vermont Health Plan (TVHP).

Section A: Member Infor	mation					
Member Name:		Date of Birth:				
Identification Number:		Telephone:				
Address:						
Section B: Statement of I revoke my previous author information as described below	ization for your use and/or o	disclosure of my protected health				
VCC and their subsidiaries, a	ffiliates, employees, officers	Il <i>not</i> affect any action BCBSVT/TVHP, s, agents and other related entities ceipt of this written notice of				
` '	copy of the Authorization to he Authorization to Release	oked o Release Information (ARI) that is Information is not attached, please				
Date of authorization (if known	wn):					
option of allowing another petheir own MRC portal. If you information via MRC portal be Permissions" tool within the	erson listed on their policy t authorized another person ut would like to revoke that portal to revoke access to y policy, but also authorized	enter ("MRC") portal gives members the to access (limited) information within listed on your policy to access your authorization, you may use the "My your PHI. If the individual identified to access your Member Resource llow.				
Center portal. I unde	_	horized to access my Member Resource box BCBSVT will deactivate my is created.				
☐ Not Applicable.						

Please provide the name of the person(s) that is no longer authorized to receive your Protected Health Information (this information should match the Authorized Person on the original Authorization to Release Information):

Name: Organization (if applicable): Address:			Name:		
			Organization (if applicable): Address: Street or Post Office Box		
Street or Post Office Box					
City Telephone:	State	Zip Code	City Telephone:	State	Zip Code
Relationship to Member: i.e. mother, attorney, neighbor, friend, benefits administrator			Relationship to Member: i.e. mother, attorney, neighbor, friend, benefits administrator		
Section D: Indiv Signature:	idual's Signat	ure		Date:	
Attorney, you <i>may</i> has required regula	be able to sign story language. ing such persor	on behalf of Complete the nal representa	the Member/Pate following and a	or agent acting und ient if the supportin attach documentatio gal department will	ng paperwork on (if
Personal Represent	ative's Name:				
Relationship to Ind	ividual:				

Please keep a copy of this document for your records and email the completed Revocation to Blue Cross and Blue Shield of Vermont, Attn: Customer Service, at Customer Service@bcbsvt.com.

NOTE: This form must be signed and sent by the Member granting the permission, not the person receiving the permission.