Form F2: Revocation of Authorization to Release Information

Use this form to revoke a Form F1: Authorization to Release Information or other Form(s) previously submitted to Blue Cross and Blue Shield of Vermont (BCBSVT) and/or The Vermont Health Plan (TVHP). This authorization may be used by currently active members, former members, or on behalf of deceased members.

Section A: Member Information

Member Name: _____ Date of Birth: _____

BCBSVT ID Number: _____

Address: _____

_____

Telephone: _____ E-Mail Address: _____

Section B: Statement of revocation

I revoke my previous authorization for your use and/or disclosure of my protected health information as described below.

I understand that this revocation of my authorization will *not* affect any action BCBSVT/TVHP, VCC and their subsidiaries, affiliates, employees, officers, agents and other related entities or others took in reliance on my authorization before receipt of this written notice of my revocation.

Section C: Description of authorization to be revoked

Please attach (if available) a copy of the Form F1: Authorization to Release Information or other BCBSVT Form(s) permitting the disclose of your protected health information that is being revoked. If a copy of the Authorization to Release Information is not attached, please provide the following information.

Date of authorization(s) (if known): ____/____/____

***Member Resource Center* — The Member Resource Center ("MRC") portal gives members the option of allowing another person listed on their policy to access (limited) information within their own MRC portal. If you authorized another person listed on your policy to access your information via MRC portal but would like to revoke that authorization, you may use the "My Permissions" tool within the portal to revoke access to your PHI. If the individual identified below was not listed on your policy but was authorized to access your Member Resource Center portal, please check the appropriate box below.

- ❑ The person(s) identified below are no longer authorized to access my Member Resource Center portal. I understand that by checking this box BCBSVT will deactivate my Member Resource account until a new password 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):

Name:_____
Organization (if applicable):_____
Address:_____
Street or Post Office Box

_____
City State Zip Code
Telephone:_____
E-Mail:_____
Relationship to Member:_____
i.e. mother, attorney, neighbor, friend, benefits administrator

Name:_____
Organization (if applicable):_____
Address:_____
Street or Post Office Box

_____
City State Zip Code
Telephone:_____
E-Mail:_____
Relationship to Member:_____
i.e. mother, attorney, neighbor, friend, benefits administrator

Section D: Individual's Signature

Signature: _____ Date: _____

If you are a personal representative, such as a Legal Guardian or an agent acting under a Power of Attorney, you *may* be able to sign on behalf of the Member if the supporting documentation has the required language. This Form shall be accompanied by such supporting documentation for BCBSVT's Legal Department to determine whether authority is granted to authorize this Form.

Personal Representative's Name: _____

Relationship to Member or Authority to act as Personal Representative: _____

Please keep a copy of this document for your records and send the completed Revocation to Blue Cross and Blue Shield of Vermont, Attn: Privacy Officer, PO Box 186, Montpelier, VT 05601, or privacyofficer@bcbsvt.com.

NOTE: This form must be signed and sent by the Member revoking the authorization, not the previously authorized individual.