



**Oklahoma State & Education Employees Group Insurance Board**  
**REVOCATION OF AUTHORIZATION TO DISCLOSE HEALTHCHOICE INFORMATION**

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**Revocation Instructions**

1. Enter the name of the member whose authorization is to be revoked.
  2. Enter the name of the person who signed the authorization.
  3. Enter the date the authorization was originally signed.
  4. Enter the date the authorization is to be revoked.
  5. Member, legal representative, spouse, or dependent age 18 or over must sign and date the revocation.
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**Complete the Authorization below**

I do hereby request that this authorization to disclose HealthChoice information of

1. \_\_\_\_\_ signed by 2. \_\_\_\_\_  
(Name of Member and/or dependent) (Enter Name of Person Who Signed Authorization)

on 3. \_\_\_\_\_ be rescinded, effective 4. \_\_\_\_\_.  
(Enter Date of Signature) (Date)

I understand that any action taken on this authorization prior to the rescinded date is legal and binding.

5. \_\_\_\_\_  
(Signature of Member, Legal Representative, or Dependent over 18) (Date)

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