Office of Management and Enterprise Services
Employees Group Insurance Department

REVOCATION OF AUTHORIZATION TO DISCLOSE HEALTHCHOICE INFORMATION

Revocation Instructions

1. Enter the name and date of birth of the member or minor dependent whose authorization is to be revoked.
2. Enter the name of the person who signed the authorization which you are now revoking.
3. Enter the date the authorization was originally signed.
4. Enter the date the authorization is to be effectively revoked.
5. Member, legal representative, spouse or dependent age 18 or over must sign and date the revocation.

Complete the Revocation Below:

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

1. ____ ________________________________
(Typed or Printed Name of Member and/or Dependent) (Date of Birth)

signed by 2.____
(Typed or Printed name of Person Who Signed Authorization)

on 3. ________________________________ be revoked, effective 4.__________________________.
(Enter Date of Previous Authorization) (Date)

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

5. ____
(Printed Name of Member, Legal Representative or Dependent Over 18)

____ ____________________________
(Signature of Member, Legal Representative or Dependent Over 18) (Today's Date)

Return to OMES EGID, 3545 NW 58th St, Ste 1000, Oklahoma City, Oklahoma 73112