



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