DOCTORS HEALTHCARE PLANS, INC.

Revocation of Consent for Release of Protected Health Information

MEMBER INFORMATION (person whose information will be released)

First Name: _____ Last Name: _____

Member ID: _____ Date of Birth: _____

Address: _____ City: _____ State: _____

I no longer authorize Doctors HealthCare Plans to use or disclose the protected health information described below:

☐ All Protected Health Information (PHI) - clinical, claims, billing, benefit, and coverage information
This authorizes the discontinuation of release of behavioral health, HIV, and substance use information.

☐ Other (specify here):

_____

_____

This information can no longer be disclosed to, and used by, the following people or organizations:

Name: _____ Last Name: _____

Relationship: _____ Date of Birth: _____

Address: _____ City: _____ State: _____

I understand that with this form, I am revoking authorization for the above individuals. I understand the revocation will not apply to information released prior to Doctors HealthCare Plans' receipt of this revocation form.

_____ _____

Member or Legal Representative* Signature Date

**Legal Representative(s) must provide documentation to support legal authority to act on behalf of Member.*

Legal Representative Name: _____ Phone: _____

Address: _____ City: _____ State: _____