TRIPLE-S SALUD
BlueCross BlueShield of Puerto Rico

AUTHORIZATION REVOCATION

Purpose: This form is used to revoke or to confirm revocation of an authorization previously given.

SECTION A: Individual revoking the authorization.

Name: _____

Address: _____

Telephone: _____ E-mail: _____

Identification Number: _____ Social Security Number: _____

SECTION B: Individual's statement of revocation.

I revoke my authorization for the use and/or disclosure of the protected health information described in the authorization (or below, if the authorization is not attached).

I understand that this revocation will *not* affect any action TRIPLE-S SALUD or others took in reliance of my authorization before receipt of this written revocation. I also understand that, if my authorization was a condition for risk evaluation, or my eligibility for benefits, Triple-S Salud may deny my subscription to a health plan or end my eligibility for benefits.

Copy of authorization attached: ☐ Yes. ☐ No (complete Section C).

SECTION C: Description of authorization revoked (complete if authorization not attached).

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

Protected Health Information Affected: The revoked authorization applied to the following protected health information:

_____

_____

Entities Authorized to Receive and Use: The revoked authorization allowed the protected health information described above to be received and used by the following persons and/or organizations:

_____ _____

_____ _____

INDIVIDUAL'S SIGNATURE

Signature: _____ Date: _____

If this revocation is signed by a personal representative on behalf of the individual, complete the following:

Personal Representative's Name: _____

Relationship to Individual: _____

YOU ARE ENTITLED TO A COPY OF THIS AUTHORIZATION REVOCATION AFTER YOU SIGN IT.

Include completed form in the individual's records.
Send copy to the Privacy Officer