BeHealthy Partnership℠
Baystate Health Care Alliance in Partnership with Health New England

One Monarch Place, Suite 1500
Springfield, MA 01144-1500
behealthypartnership.org

BeHealthy Partnership℠ Revocation Of Authorization To Release Protected Health Information Form

INSTRUCTIONS:
This form is to be used to **revoke authorization** to release protected health information to a ***previously appointed personal representative.***

- Type or print all responses. This form must be filled out completely to be valid.
- **Important:** The Member ID # is found on your BeHealthy Partnership card.
- On receipt by BeHealthy Partnership, please note that it may take up to 14 days to process the revocation.
- Return completed form, by mail or fax to: BeHealthy Partnership, Attention: Enrollment Department, One Monarch Place, Suite 1500, Springfield, MA 01144-1500 (Fax: (413) 233-2635)

Member ID # (BeHealthy Partnership card #):	
Member Name:	
Home Address:	
Home Telephone:	Date of Birth:

Representative Name:		
Address:		
Home Telephone:	Cell:	Work:

Terms of this Authorization:

a. I hereby revoke the authorization that I previously provided to BeHealthy Partnership for release or disclosure of my protected health information to the representative (facility/person) identified above.
b. I understand that this revocation will be effective immediately upon BeHealthy Partnership's receipt and processing. This revocation will not have any effect on any action taken based on my prior authorization to the identified representative (facility/person) before receipt and process of this written revocation by BeHealthy Partnership.
c. I understand that this revocation does not revoke any other previous authorizations to release information that I have provided to BeHealthy Partnership with the exception of the representative (facility/person) identified above.
d. This revocation will not affect court orders or other disclosures where such disclosures are permitted or required by law without a member's authorization.

I have read and understand the terms of this revocation and by signing below I authorize BeHealthy Partnership to process this revocation on my behalf.

_____ _____

Signature of Individual Authorizing Revocation | Date

If Individual is a minor or is otherwise unable to sign, please sign and complete below. (If other than Parent, please attach documentation, such as court appointment, health care proxy, etc.)

_____ _____ _____

Signature of Authorized Legal Guardian, Health Care Agent or other Personal Representative | Relationship | Date