REQUEST TO REVOKE AUTHORIZATION FORM

Return to:
Benefit Services of Hawaii, Inc.
Attn: Privacy Office
P.O. Box 840
Honolulu, HI 96808-0840
808.538.8900 phone

Please complete and sign this form to revoke or cancel an authorization provided to Benefit Services of Hawaii, Inc. (BSHI) for the use, request and/or disclosure of your protected health information (PHI) or the appointment of a personal representative. Use this form when the revocation effective date is before the expiration date or event documented on your authorization.

PART A: PARTICIPANT REVOKING THE AUTHORIZATION

First Name		MI	Last Name
Social Security Number	Phone Number	Street Address	

PART B: REVOCATION INFORMATION

I understand that this revocation will not affect any action BSHI or others took in reliance on my authorization before receipt of this written revocation. Upon request, I am entitled to receive a copy of this signed form.

PART C: DESCRIPTION OF AUTHORIZATION REVOKED

Please attach a copy of the authorization you are revoking. A copy of the authorization is attached:
☐ Yes
☐ No (Please proceed to next section)

If you do not have a copy, please provide a description of the authorization in the sections below.

1. Please describe the time period or activity covered under the authorization being revoked.
   a. ☐ From date: _____/_____/________ Through date: _____/_____/_______
   b. ☐ Completion of the following activity (please describe):

   ____

   ____

2. Please indicate the person(s) and/or organization(s) Benefit Services of Hawaii is authorized to request from and/or release to:

Name:
Name:
Name:

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I,____, request that you revoke my authorization for the use and/or disclosure of the protected health information described in the attached authorization (or as described in Part C).

Signature: ____ **Date:** __________________________
(Participant or Personal Representative)

If this request is being made by a personal representative on behalf of the participant, please provide the following:

Personal Representative's Name:
(Please Print) ____

Relationship to Participant: ____

BSHI USE ONLY

Date Received:	Received By:	Unit:
Date Completed by Unit:	Handled By:	Unit:
Date Par Notified:	Handled By:	Unit:

4/04