



Maricopa County

Employee Benefits and Health

301 West Jefferson, Suite 3200
Phoenix, AZ 85003-2143
Phone: 602 506-1771
www.maricopa.gov

REVOCATION OF AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION

Purpose: The Health Insurance and Portability Act of 1996 (HIPAA) provides an individual the right to revoke a previous authorization to use or disclose protected health information at any time provided that the revocation is in writing. A revocation of authorization will not affect any action taken before receipt of this notice.

Section A: Individual Revoking the Authorization

Full Name: _____ Employee I.D.: _____
Address: _____ Date of Birth: _____

Telephone No.: _____

Email: _____

Section B: Revocation Request

I hereby request that the following authorization(s) be revoked (*check all boxes that apply*):

- All authorizations for Maricopa County to release my protected health information to StayWell (wellness program administrator)
- All authorizations for StayWell to release my protected health information to any third party
- All authorizations for Quest Diagnostics (biometric screening and nicotine test administrator) to release my protected health information to any third party
- Other, please specify: _____.

Section C: Signature Required

I understand that signing and submitting this form will end my previous authorizations to release information to those persons or entities listed in Section B. This revocation will not be effective until it is received by the person otherwise authorized to disclose records. I further understand that the revocation will only apply to further disclosures or actions regarding my protected health information and cannot cancel actions or disclosures made while an authorization was previously in effect and valid. I understand there may be certain wellness incentives or rewards under my health plan that I may not be eligible for as a result of revoking my previous authorizations.

I will retain a copy of the revocation form for personal reference. I understand that a copy of this revocation will also be kept on file in the records of the Maricopa County Employee Benefits Department and each person and entity named above for the period designated for such retention.

Signature of Individual

Date

Relationship if signed by other than Individual: _____ (verification of authority required)

Please send this completed form to:

Maricopa County Employee Benefits Division, 301 W. Jefferson St., Suite 3200, Phoenix, AZ 85003

Questions: 602-506-1010