HealthEquity®

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HIPAA AUTHORIZATION REVOCATION

Note: Any covered participant over the age of 18 requires a separate Authorization Form to be completed.

SECTION A - INDIVIDUAL AUTHORIZING USE AND/OR DISCLOSURE OF PROTECTED HEALTH INFORMATION (PHI)

Participant Name:	
Mailing address:	
City, State, Zip:	Phone:
Social Security # or Your Participant ID # *as assigned by your program sponsor:*	

SECTION B - STATEMENT OF REVOCATION

I revoke my previous authorization for your use and/or disclosure of my protected health information (PHI) as described below.

I understand that this revocation of my authorization will NOT affect any action you or others took in reliance on my authorization before they received this written notice of my revocation.

Copy of authorization attached: ☐ Yes ☐ No

SECTION C - DESCRIPTION OF AUTHORIZATION REVOKED *(COMPLETE THIS SECTION IF AUTHORIZATION NOT ATTACHED)*

Date of authorization (if known): _____/_____/_____.

Protected Health Information: *The revoked authorization authorized use and/or disclosure of the following PHI.*

Entities or Persons Authorized to Use or Disclose: *The revoked authorization authorized the following persons and/or organizations (or classes of persons and/or organizations), including us, to make use of or to disclose the protected health information described above.*

Entities or Persons Authorized to Receive and Use: *The revoked authorization authorized the following persons and/or organizations (or classes of persons and/or organizations), including us, to receive and/or use the protected health information described above.*

SECTION D - INDIVIDUAL'S SIGNATURE

Print Name:	
Signature:	Date:
If this revocation is signed by a personal representative on behalf of the individual, complete the following:	
Personal Representative's Name:	
Signature:	Date:
Relationship to Individual:	

AFTER YOU HAVE SIGNED THE HIPAA AUTHORIZATION, KEEP A COPY FOR YOUR RECORDS.

Submit to: HealthEquity, Inc.
Claims Administrator
PO Box 14053
Lexington, KY 40512

Fax: 866.672.3703