Lifetime Benefit Solutions

Protected Health Information Authorization Cancellation Form

Purpose: This form should be completed when a member wishes to cancel an existing authorization permitting Lifetime Benefit Solutions, Inc. to release protected health information (PHI) to another individual or organization. If there is currently more than one person authorized, each name must be listed below. If you only list one individual, only the authorization for that individual will be revoked.

Please complete both sections if you wish to cancel your authorization.

I. I wish to revoke my authorization permitting Lifetime Benefit Solutions to release my PHI to:

_____

_____

II. Members' last four digits of social security number: _____

Effective Date of Cancellation:_____

Signature: You may refuse to sign this. However, without a signature, we cannot process your cancellation request.

I, (please print) _____, have had full opportunity to read and consider the contents of this authorization revocation form. I understand that, by signing this form, I am confirming that the information contained on this form is correct.

I understand that revocation of the authorization will not affect any action taken in reliance on this authorization before written notice of revocation is received.

Signature: _____ Date: _____

If a personal representative on behalf of the individual signs this, please complete the following:

Personal Representative's Name: (please print) _____

Description of Personal Representative's Authority (a power of attorney, legal guardian or state executor):

_____

Personal Representative's Signature: _____

Date: _____

Please complete and return this form to:
Lifetime Benefit Solutions, Inc.
FSA Dept.
PO Box 211126
Eagan, MN 55121
FAX: 877-256-7228

PLEASE RETAIN A COPY OF THIS FORM FOR YOUR RECORDS