



National Dental Grid Product Claims Administrator
P. O. Box 21951
Eagan, MN 55121

Protected Health Information Authorization Cancellation Form

Purpose: This form should be completed when a member wishes to cancel an existing authorization permitting Excellus Health Plan, 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 Excellus Health Plan to release my PHI to:

II. Member Identification 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 the
claim address listed on your member identification card.**

PLEASE RETAIN A COPY OF THIS FORM FOR YOUR RECORDS