HIGHMARK | HIGHMARK

Revocation of Authorization for Disclosure of Protected Health Information (PHI)

Highmark Blue Cross Blue Shield, Highmark Blue Shield & Affiliated Health Plans**

Please return completed form to:
Highmark, Inc
Customer Service
P.O. Box 890035
Camp Hill, PA 17089

Please complete all fields. If information is missing, we will return the form to you for completion. If you need help with this form, contact the Customer Service number listed on your member identification card.

You have the right under HIPAA to cancel (revoke) permission you previously gave Highmark to share (disclose) your health information with certain individuals or organization. This is known as a revocation of Authorization for Disclosure of Protected Health Information.

MEMBER INFORMATION - (Please PRINT the information for the member whose PHI should not be disclosed.)		
Member Name:		Date of Birth:
Address:		
City:	State:	Zip:
Phone (Daytime):		Member ID:

AUTHORIZATION(S) TO BE REVOKED - (Please identify the information that should be cancelled.)

☐ I revoke ALL active authorizations for disclosure of PHI on file

☐ I revoke the authorization I signed on the following date: _____
disclosing information to: _____

☐ I request the authorization I signed on the following date: _____
disclosing information to: _____
be modified to cancel my authorization to release the following specific protected health information:
_____

I revoke my authorization for Highmark and its subsidiaries and affiliates (Highmark) to disclose my protected health information (PHI) as described above. By signing the below, I understand and agree that:

- This request applies only to the authorization(s) for disclosure as listed above;
- This request will not apply to any disclosures of PHI authorized by me prior to the date that Highmark receives and executes this request;
- This request will not apply to any disclosures of PHI by Highmark that are allowed or required by law;
- The authorization(s) listed above will be revoked on the date my request is processed.

_____ _____
Signature of Member or Personal Representative* Date

_____ _____
Printed name of Member or Personal Representative Relationship to Member

* If you are signing this form as a Personal Representative for the member, you must attach copies of your authorization as required by state law to represent the member (e.g., healthcare power of attorney, healthcare surrogate, or guardianship papers).

Disclosures:

Benefits and/or benefit administration may be provided by or through the following entities, which are independent licensees of the Blue Cross Blue Shield Association:

Western and Northeastern PA: Highmark Inc. d/b/a Highmark Blue Cross Blue Shield, Highmark Choice Company, Highmark Health Insurance Company, Highmark Coverage Advantage Inc., Highmark Benefits Group Inc., First Priority Health, First Priority Life, Highmark Senior Health Company, Highmark Care Benefits Inc., or Gateway Health Plan, Inc. d/b/a Highmark Wholecare.

Central and Southeastern PA: Highmark Inc. d/b/a Highmark Blue Shield, Highmark Benefits Group Inc., Highmark Health Insurance Company, Highmark Choice Company, Highmark Senior Health Company, or Gateway Health Plan, Inc. d/b/a Highmark Wholecare.

PA: Your plan may not cover all your health care expenses. Read your plan materials carefully to determine which health care services are covered. For more information, call the number on the back of your member ID card or, if not a member, call 866-459-4418.

Delaware: Highmark BCBSD Inc. d/b/a Highmark Blue Cross Blue Shield or Highmark BCBSD Health Options Inc. d/b/a Highmark Health Options.

West Virginia: Highmark West Virginia Inc. d/b/a Highmark Blue Cross Blue Shield, Highmark Health Insurance Company, Highmark Senior Solutions Company, or Highmark Health Options West Virginia Inc. d/b/a Highmark Health Options and Highmark Blue Cross Blue Shield. Visit https://www.highmarkbcbswv.com/networkaccessplan to view the Access Plan required by the Health Benefit Plan Network Access and Adequacy Act. You may also request a copy by contacting us at the number on the back of your ID card.

Western NY: Highmark Western and Northeastern New York Inc. d/b/a Highmark Blue Cross Blue Shield.

Northeastern NY: Highmark Western and Northeastern New York Inc. d/b/a Highmark Blue Shield.

All references to “Highmark” in this document are references to the Highmark company that is providing the member’s health benefits or health benefit administration and/or to one or more of its affiliated Blue companies.