



**STATE OF LOUISIANA - OFFICE OF GROUP BENEFITS
 REVOCATION OF AUTHORIZATION FOR USE OR DISCLOSURE OF
 PROTECTED HEALTH INFORMATION**



I hereby revoke authorization to the Office of Group Benefits' (OGB) to use or disclose of my protected health information as follows:

MEMBER/DEPENDENT NAME		DATE OF BIRTH		MEMBER ID NUMBER OR LAST 4 DIGITS OF SSN	
ADDRESS			CITY		STATE
					ZIP CODE
EMAIL ADDRESS			TELEPHONE (PRIMARY)		TELEPHONE (ALTERNATE)

Covering the period(s) of health care coverage:

FROM (DATE)	TO (DATE)

INFORMATION SUBJECT TO THE REVOCATION

I understand that uses and disclosures of my health information may have already occurred in reliance upon my previously issued authorization and that this revocation does not apply retroactively.

The Office of Group Benefits and its workforce members and officers are hereby released from any legal responsibility or liability for any use or disclosure that occurred in reliance upon my previous authorization.

SIGNATURE OF HEALTH PLAN MEMBER/DEPENDENT OR REPRESENTATIVE

DATE

PRINTED NAME OF HEALTH PLAN MEMBER/DEPENDENT OR REPRESENTATIVE

REPRESENTATIVE RELATION TO MEMBER/DEPENDENT

SIGNATURE OF WITNESS

DATE