Sentara Health Plans

REVOCATION OF AUTHORIZATION

Read this information first:

You should complete this form if you wish to (1) revoke (cancel) the authorization for Optima Health to use or disclose your medical information to your personal or designated representative; or (2) opt-out of receiving any fundraising communications. This revocation will be effective immediately upon receipt of this completed form to Sentara Health Plans.

**Mail this form to: Sentara Health Plans Compliance
PO Box 66189
Virginia Beach, VA 23466
or email to: shpprivacy@sentara.com

Privacy Statement: Please be aware that email and text communication can be intercepted in transmission or misdirected.

Step 1: Complete the demographic information for the person receiving services

1. ______________________________ Member Name

2. ______ / ______ / __________ Date of Birth

3. ______________________________ Member ID # or last 4 digits of SSN #

Step 2: Tell us who you are withdrawing authorization to use or receive your medical information

4. ______________________________ Name of Authorized Representative

5. ______________________________ Address of Authorized Representative

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Step 3: Complete your acknowledgement that you understand that:

- By completing this revocation form, the person listed will no longer have access to your protected health information or you will no longer receive any fundraising communications;
- Revoking this authorization will not affect your benefits, claim payments, or care delivered under your benefit plan; and
- You have a right to receive a copy of this signed revocation form.

______________________________ Person revoking authorization signature

______ / ______ / __________
Month Day Year