Sentara Health Plans

REMOVAL OF AUTHORIZATION FOR USE OR DISCLOSURE OF HEALTH PLAN INFORMATION

You should complete this form if you wish to remove the authorization for Sentara Health Plans to use or disclose your health plan information to your authorized person. This removal 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. _____ 2. _____
Member Name — Date of Birth (MM/DD/YYYY)

3. _____ 4. _____
Member ID Number — Phone Number (specify if cell)

5. _____
Street Address, City, State and Zip Code

Step 2: Tell us who you are removing authorization to use or receive your health plan information

6. _____
Name of Authorized Person(s)

7. _____
Address of Authorized Person(s)

Step 3: Complete your acknowledgement that you understand that:

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

_____ _____
Person removing authorization signature — Date (MM/DD/YYYY)