REVOKING AN AUTHORIZATION
OR
RESTRICTING USES AND DISCLOSURES OF INDIVIDUALLY IDENTIFIABLE HEALTH INFORMATION

You may revoke an existing authorization by completing **Section I** of this form.

To restrict uses or disclosures of your individually identifiable health information, please complete **Section II** of this form.

Date:	**UserID:**
Name:	**Telephone:**
Address 1:	**City, State:**
Address 2:	**Zip Code:**

Section I – Revoking an Authorization

This section applies to authorizations that you have sent to FSAFEDS, which allow FSAFEDS to disclose your information to another person or entity (such as an attorney). You may revoke an authorization by checking the appropriate item below, signing this section, and returning the completed form by mail or fax to:

FSAFEDS Program
P.O. Box 36880
Louisville, KY 40233
Fax: 1-866-643-2245

I hereby revoke any and all authorizations to release my individually identifiable health information to any third party.

I hereby revoke my authorization dated , which authorized FSAFEDS to release information to: ________________________________

____

I understand that, as of the date it receives this revocation, FSAFEDS will no longer disclose information to the person/entity named in the authorization, except to the extent that FSAFEDS has relied upon that authorization.

____
Signature of employee, spouse, dependent   Date

____________________________________   ____________________________________
Printed name of personal representative   Relationship to employee, spouse, dependent or representative's authority to act

Section II – Restricting Uses or Disclosures of Information by FSAFEDS

Use this section to notify FSAFEDS of any restrictions you may wish to place on access to your account information. You may restrict access to certain individual(s) by indicating their name(s) below, signing this section, and returning both pages of the completed form by mail or fax to:

FSAFEDS Program
P.O. Box 36880
Louisville, KY 40233
Fax: 1-866-643-2245

FSAFEDS is hereby notified that it cannot disclose any of my individually identifiable health information to the following individuals: ______________________________

____

____

______________________________ Signature of employee, spouse, dependent

Date

______________________________ Printed name of personal representative

______________________________ Relationship to employee, spouse, dependent or representative's authority to act