PARAMOUNT

AUTHORIZATION REVOCATION NOTICE

I hereby revoke my Authorization to Disclose Health Information.

Person/organization who was authorized to receive the information: _____

I understand Paramount will disclose my medical information when required to do so by federal, state, or local law, and that there is no provision to revoke under these circumstances.

I understand that the revocation will not apply to information that has already been released in response to the authorization.

I understand that if the person or entity that received the information is not a health care provider or health plan covered by federal privacy regulations, the information could be re-disclosed by such person or entity and will likely no longer be protected by the federal privacy regulations.

Signature of Member or Legally Authorized Representative _____

Date _____

Relationship to Member _____

Witness _____

Office Use Only

Date received _____

Signature_____Title_____

Date _____