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 __________