

Authorization Cancellation

Please read these instructions carefully before completing this form.

When to Use This Form

You must complete this form if you want to cancel and Authorization to release information about you that is currently on file with Prime Therapeutics.

- Parents or a legal guardian may sign for a minor unless the information being released is about:
- pregnancy,
- sexually transmitted disease,
- alcohol or drug abuse,
- abortion,
- hepatitis B shot, or
- mental illness of a minor.

For these types of records, the minor must sign the authorization.

How to Complete This Form

This form must be complete and signed by:

- The person whose Authorization is on file, or
- The parent or legal guardian of a minor whose Authorization is on file except as listed above, or
- The personal representative of the person whose Authorization is on file (e.g., power of attorney, conservator, legal guardian, executor).

To complete this form:

- Fill in the name, member identification and date of birth of the person whose Authorization is on file.
- Fill in the types of information you want Prime to discontinue from release. Fill in the name and address of the person or group you would like to stop from seeing your information.
- Sign and date the form.
- If you are signing on behalf of the Member, please complete the Personal Representative section of the form and include your documentation of legal status, such as Power of Attorney.

Mail or Fax This Form to:

Prime Therapeutics LLC
Attention: Privacy Officer
P.O. Box 64812
St. Paul, MN 55164-0812

Fax: 866-470-8807

Note: Under the law, an authorization for use or disclosure of psychotherapy notes cannot be combined with an authorization for use or disclosure of other health care information.

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Member Information

(Person granting release of information)

Member Name _____

Member ID _____

Group Name _____

Date of Birth _____

Social Security Number _____

Cancellation Statement

I cancel my authorization to release the following information (Check all that apply)

- Address, date of birth, membership status
- Benefits
- Claims
- Psychotherapy notes
- Premium information
- Other, specify _____

I cancel my authorization for _____

to release information to Prime Therapeutics.

I cancel my authorization for Prime Therapeutics to release information to:

Name _____

Address _____

Phone Number _____

I understand that my cancellation of this Authorization does not affect any release of information processed before I canceled it.

If my Authorization was a condition of my enrollment or claim(s) processing, I understand that my cancellation may cause Prime Therapeutics to decline my enrollment or my claims because they do not have all the information they need.

X Signature of Member Date

Personal Representative

If this request is by a personal representative on behalf of the Member, complete the following and include your documentation of legal status, such as Power of Attorney.

X Signature of Parent or Date

Other Personal Representative

Personal Representative's name (please print)

Relationship to member _____

Personal Representative's address

Personal Representative's area code and phone number

Note: You have a right to keep a copy of this notice after you sign it.