**Revocation of Authorization**

Please read these instructions carefully before completing this form.

**When to use this form** You must complete this form if you want to revoke an authorization to release information about you that is currently

on file with Prime Therapeutics Pharmacy.

**To complete this form** ■ Fill in the patient’s name, ID and Group numbers (found on your health insurance card), and date of birth

■ Fill in the name, address and phone number of the person who is

NO longer approved to receive the information

■ This form must be signed and dated by ONE of the following people:

→ Patient

→ Parent or legal guardian of a minor, except† in cases of:

› Pregnancy

› Sexually transmitted disease

› Alcohol or drug abuse

› Abortion

› Hepatitis B shot

› Mental illness of a minor

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

→ Personal representative

› Must provide legal status documents (e.g., health care power of attorney)

**Mail, fax or email this form to:** Prime Therapeutics Pharmacy LLC

Attention: Pharmacy Manager/Privacy Representative

6870 Shadowbridge Drive, Ste. 111

Orlando, FL 32812

**Fax:** 866-364-2673

**Email**: [specialtyescalations@primetherapeutics.com](mailto:specialtyescalations@primetherapeutics.com)

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**Revocation of Authorization**

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**Patient information** (Person revoking release of information) **\*Required information**

Patient name\* Date of birth\*

Patient address\* \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient ID\* Group number

Member ID and Group number are found on your health insurance card

**My revocation request applies to information including:**

Personal and/or health information created or held by Prime Therapeutics. This information may include my address, date of birth, membership status, and medical claim prescription history.

**You may NO LONGER release this information to:**

Name\* Phone number\* Address\*

Email \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Fax number \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I understand that this revocation will not apply to any information shared before the date this form is received.

Signature of patient Date

X

**Personal representative**

If you are signing on behalf of the patient, you must provide legal status documents (e.g., health care power of attorney or legal guardianship).

Signature of parent or personal representative Relationship to patient Date

X

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