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.

To complete this form

- Fill in the member'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:

  → Member

  → 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 or fax this form to:

Prime Therapeutics LLC
Attention: Revocation Form Processing
P.O. Box 64812
St. Paul, MN 55164-0812
Fax: 877.254.3794

Revocation of Authorization

Member information (Person revoking release of information) ***Required information**

Member name* _____ Date of birth* _____

Member address* _____

Member 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 member Date

X _____ _____

Personal representative

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

Signature of parent or personal representative Relationship to member Date

X _____ _____ _____