



REVOCAION OF CONFIDENTIAL COMMUNICATION

This form is for subscribers and members covered by the GEHA Health, GEHA Connection Dental Federal, CONNECTION Dental *Plus* plans and/or Connection Vision Plan. Please place a check mark in front of each plan you want this Revocation of Confidential Communication request to be applied.

NOTE: At least one line MUST be checked for this form to be valid.

- GEHA Health Plan (includes Connection Vision Plan)
- GEHA Connection Dental Federal Plan (includes Connection Vision Plan)
- CONNECTION Dental *Plus* Plan (includes Connection Vision Plan)
- CONNECTION Vision Plan only

NOTE: ALL AREAS OF THIS FORM MUST BE COMPLETED IN FULL. INCOMPLETE FORMS WILL BE CONSIDERED INVALID AND RETURNED.

Subscriber/Member Information:

Subscriber Name: _____

Address: _____

Subscriber ID Number: _____ **Telephone Number:** _____

Patient Name: _____ **Date of Birth:** _____

I previously signed a Confidential Communication, requiring GEHA to send correspondence to an alternate address and direct telephone calls to an alternate number.

I hereby revoke such Confidential Communication effective the date signed below, but **understand that this will require up to fifteen (15) working days from the date received by GEHA to execute this request, and forward to GEHA's business associates, who partner with us to assist in providing services in areas such as pharmacy, radiology, precertification, vision, etc.** (as outlined in GEHA's Notice of Privacy Practices available at www.geha.com). Information may continue to be sent to the alternate address and telephone calls may be directed to the alternate number up to that time. I also understand that this revocation applies to all protected health information, regardless of dates, including the previous time period where Confidential Communications applied.

Date: _____

Patient or Legal Representative Signature: _____

Relationship to patient: _____
(i.e. parent, legal guardian, power of attorney, etc.)

Note: If the signature is not that of the patient or the parent when the child is a minor, appropriate legal documentation is required to accept the signature.

PLEASE RETAIN A COPY FOR YOUR RECORDS AND RETURN THE ORIGINAL SIGNED FORM TO:

**GEHA
ATTN: Confidential Communication Revocation
P.O. Box 438
Independence, MO 64051-0438
FAX: 816-257-3283**