REVOCATION OF RESTRICTION TO DISCLOSE PROTECTED HEALTH INFORMATION

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 Restriction 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 Restriction, stopping GEHA from disclosing my protected health information to:

Name: ______________________ **Phone Number:** ______________

Address: ______________________________

Relationship to You: ______________________________

I hereby revoke such Restriction 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), and information may continue to not be disclosed up to that time. I also understand that this revocation applies to all protected health information, regardless of dates, and the previously restricted time period may also be discussed with the person previously restricted.

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: Restriction Revocation
P.O. Box 438
Independence, MO 64051-0438
FAX: 816-257-3283