american greetings

Request for Revocation of Authorization

Purpose: This form is used to revoke or to confirm revocation of an authorization previously given to American Greetings Corporation

SECTION A: Individual Requesting Revocation of Authorization

Individual's Name: _____

Address: _____

Telephone: _____ E-mail: _____

Social Security #: _____

Copy of authorization attached: ☐ Yes ☐ No

Date of authorization (if known): _____

SECTION B: Description of Authorization Revoked

Protected Health Information: The revoked authorization had authorized use and/or disclosure of the following protected health information:

_____

_____

_____

Entities Authorized to Use or Disclose: The revoked authorization had authorized the following persons and/or organizations (or classes of persons and/or organizations), to make use of and/or to disclose the protected health information described above:

_____

_____

_____

Entities Authorized to Receive and Use: The revoked authorization had authorized the following persons and/or organizations (or classes of persons and/or organizations) to receive and/or use the protected health information described above:

_____

_____

_____

Section C: SIGNATURE

I revoke my authorization for the Company's use and disclosure of my protected health information as described below.

I understand that revocation of my authorization will *not* affect any action American Greetings or others took in reliance on my authorization before they received this written notice of my revocation. I also understand that, if my authorization was a condition of my enrollment in the Company's health plan or of my eligibility for benefits, or was for protected health information that the Company requested to adjudicate payment of a claim involving me, the Company may disenroll me from the health plan, end my eligibility for the benefits, or not pay the claim.

Patient's Printed Name: _____ **Date:** _____

Patient's Signature: _____ **Date:** _____

If this authorization is signed by a personal representative on behalf of the individual, complete the following:

Patient's Representative Printed Name: _____ **Date:** _____

Patient's Representative Signature: _____ **Date:** _____

Relationship to Individual: _____

YOU ARE ENTITLED TO A COPY OF THIS REVOCATION AUTHORIZATION AFTER YOU SIGN IT.

Revised 5/2021