DEPARTMENT OF HEALTH SERVICES
Division of Medicaid Services
F-13160 (08/2020)

STATE OF WISCONSIN
P.L. 104-191

WISCONSIN CHRONIC DISEASE PROGRAM (WCDP)

HIPAA PRIVACY REVOCATION OF AUTHORIZATION

The Privacy Rule standards of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) P.L. 104-191 require DHS, as a covered entity, to implement processes that give patients certain rights regarding individually identifiable health information. The information requested on this form is needed to comply with those Privacy Rule requirements.

Provision of the information that is requested on this form is voluntary. Although the use of this version of the form is voluntary, all of the information outlined on this form is mandatory.

Personally identifiable information requested on this form is mandatory in order to process your request and will only be used for this purpose.

INSTRUCTIONS: Mail this completed form to the following address:

WCDP
Member Services
PO Box 6410
Madison WI 53716

You are entitled to a copy of this revocation of authorization after you sign it.

SECTION I – MEMBER INFORMATION

Name – Last, First, Middle Initial	WCDP Identification Number
Address – Street, City, State, ZIP Code	Phone Number ( )

SECTION II – STATEMENT OF REVOCATION

I revoke my previous authorization, or part of my previous authorization, for the Wisconsin Chronic Disease Program (WCDP) use and disclosure of my health information records as described below.

I understand that this revocation of my authorization will *not* affect any action the WCDP or others took in reliance of my authorization before receiving this written notice of my revocation.

Initials: _____

Copy of authorization attached: ☐ Yes ☐ No

Date of authorization (if known): _____

SECTION III – DESCRIPTION OF AUTHORIZATION REVOKED

Do you wish to revoke all of the previous authorization or only part of the previous authorization?
Select one of the boxes below and complete all information on this form.

☐ Please revoke the entire previous authorization.
☐ Please revoke only part of the authorization.

Health Information: Describe the health information, including the dates of the records that were previously authorized for the use of or for disclosure by the WCDP. If only a partial revocation, please provide information as to which part of the authorization you wish to revoke.

_____

_____

SECTION III – DESCRIPTION OF AUTHORIZATION REVOKED (Continued)

Person or Organization Authorized to Use or Disclose: Name or specifically identify the persons or organizations, including the WCDP, previously authorized to make use of or disclose the health information described previously:

Name	Phone Number ( )
Address	
Name	Phone Number ( )
Address	

Person or Organization to Receive and Use: Name or specifically describe the persons or organizations to whom you had authorized the WCDP to disclose or let use the health information described previously:

Name	Phone Number ( )
Address	
Name	Phone Number ( )
Address	

SECTION IV – SIGNATURES

Please sign the form and complete the appropriate information.

SIGNATURE – Member	Date Signed

If this authorization is signed by a personal representative on behalf of the member, provide a copy of the documentation to support the representation and complete the following:

Name – Personal Representative	Relationship to Member
SIGNATURE – Personal Representative	Date Signed

RESET FORM