SOUTH CAROLINA DEPARTMENT OF HEALTH AND HUMAN SERVICES
Healthy Connections MEDICAID

REVOCATION OF AUTHORIZATION TO DISCLOSE HEALTH INFORMATION

I do hereby request that the authorization to disclose health information of ______________________________
Name of Beneficiary

signed by ____ ______________________
Enter Name of Person Who Signed the Authorization *Date of Signature*

be withdrawn, effective_______________.
Date

______________________________ ______________________________
Signature of Beneficiary *Date*

______________________________ ______________________________
*Signature of Legal Representative** *Date*

*Documentation of the authority to act as the legal representative for the beneficiary must be attached.

SCDHHS HIP05
Rev. 11/17