REVOCATION OF AUTHORIZATION
TO DISCLOSE HEALTHCHOICE INFORMATION

Revocation Instructions

1. Enter the name and date of birth of the member or minor dependent whose authorization is to be revoked.

   _____ _____
   Name Date of birth

2. Enter the name of the person who signed the authorization you are revoking.

   _____
   Name

3. Enter the date the authorization was originally signed.

   _____
   Signature date

4. Enter the effective date of the revocation of authorization.

   _____
   Revocation date

5. Member, legal representative, spouse or dependent age 18 or over must sign and date the revocation.

Complete the Revocation Below:

I do hereby request that the authorization to disclose HealthChoice information indicated above be revoked. I understand that any action taken on the authorization prior to the revocation date is legal and binding.

_____
Printed name of member, legal representative or dependent over 18

_____ _____
Signature of member, legal representative or dependent over 18 Today's date

Return to OMES Employees Group Insurance Division
P.O. Box 58010, Oklahoma City, OK 73157-8010