OptimaHealth

Revocation of Authorization

Read this information first:

You should complete this form if you wish to (1) revoke (cancel) the authorization for Optima Health to use or disclose your medical information to your personal or designated representative; or (2) opt-out of receiving any fundraising communications. This revocation will be effective immediately upon receipt of this completed form to Optima Health.

*****Mail this form to: Compliance Optima Health, 4417 Corporation Lane, Virginia Beach, VA 23462 or email to: shpprivacy@sentara.com**

Step 1: Complete the demographic information for the person receiving services/fundraising information:

1. _____ 2. ___ ___/ ___ ___/ ___ ___ ___ ___
Name Date of Birth

3. _____
Member ID # or SSN #

Step 2: Tell us who you are withdrawing authorization to use or receive your medical information:

4. _____
Name of Authorized Representative

5. _____
Address of Authorized Representative

OR

6. Check box to opt-out of all fundraising communications ☐

Step 3: Complete your acknowledgement that you understand that:

- **By completing this revocation form, the person listed will no longer have access to your protected health information or you will no longer receive any fundraising communications;**
- **Revoking this authorization will not affect your benefits, claim payments or care delivered under your benefit plan; and**
- **You have a right to receive a copy of this signed revocation form.**

7. _____ _____
Person revoking authorization signature Date