L.A. Care HEALTH PLAN®

Return form to:
L.A. Care Health Plan
CSC – Authorized Rep Form
1200 West 7th Street
Los Angeles, CA 90017

AUTHORIZED REPRESENTATIVE – REVOCATION FORM

This form may be used to revoke (remove) a previously appointed Authorized Representative. If you choose to submit this form, it must be filled out completely and returned to L.A. Care at the address listed on this form.

Section 1: Member Information			
Member First Name:	**MI:**	**Last Name:**	
Street Address:	**City:**	**State:**	**Zip Code:**
Email:	**Home Phone #:**	**Cell Phone #:**	
Member ID#:		**Date of Birth (*MM/DD/YYYY*):**	

Section 2: Authorized Representative to be Removed			
Representative First Name:	**MI:**	**Last Name:**	
Street Address:	**City:**	**State:**	**Zip Code:**
Email:	**Home Phone #:**	**Cell Phone #:**	
Relationship to Member:		**Date of Birth (*MM/DD/YYYY*):**	

You must:

- review and completed the form before signing.
- provide all information required by L.A. Care.
- understand that this revocation will not affect any disclosures already made based on my prior authorization before this request to revoke has been received and processed by L.A. Care.
- understand that my treatment, payment, enrollment, or eligibility for benefits are not affected by whether or not I sign this form.

By signing below, I revoke my authorization for the use and disclosure of my protected health information to the representative identified on this form.

Today's Date	**Requester's Printed Name**	**Requester's Signature**

Requester's Identifying documentation attached (*A photocopy of one of the following*):

☐ Valid U.S Driver's License ☐ Valid DMV Identification Card ☐ Birth Certificate
☐ Passport/ID Card ☐ Government Issued Photo ID Card ☐ Other: _____

Requester's legal authority to request this change:

☐ Self ☐ Parent/Guardian ☐ Conservator ☐ Power of Attorney ☐ Other: _____
Note: Other than self, you must attach legal documentation to verify that you have legal authority to request this change.

If no identification is attached, signature must be notarized.

Please place stamp here. Not official unless stamped by a Notary Public.
Notary services are not provided or covered by L.A. Care, fees may apply

_____ _____/_____/_____
Notarized by **Date (MM/DD/YYYY)**

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Toll-free FAX: **1.844.657.7272** - This is a secure fax number. You may include a cover sheet marked "Confidential". Please use caution when faxing Protected Health Information (PHI).

To download a copy of this form please visit **lacare.org**. For questions regarding this form or how to submit this form, please contact Member Services at **1.888.839.9909** (TTY **711**). We are available 24 hours a day, 7 days a week. This call is free.

You can get this form for free in Arabic, Armenian, Chinese, Farsi, Khmer, Korean, Russian, Spanish, Tagalog, Vietnamese or other formats, such as large print, braille, or audio. Call **1.833.522.3767**. TTY/TDD users should call **711**. We are open 24 hours a day, 7 days a week. The call is free.

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