



**Flagstaff Unified School District #1**  
**Form to Revoke/Terminate a Prior Authorization**

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I, \_\_\_\_\_, hereby **revoke/terminate** an authorization that I made on \_\_\_\_\_, 20\_\_ regarding the use or disclosure of my health information.

1. Specific person/organization/or class of persons who was authorized to **provide** the information:

\_\_\_\_\_

2. Specific person/organization/or class of persons who was authorized to **receive** and use the information:

\_\_\_\_\_

3. Specific **description of the information that was allowed to be used or disclosed.**

*(Include dates as appropriate):*

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

4. I understand that the revocation/termination is only effective **after** it is received and logged by the Privacy Officer. I understand that any use or disclosure made prior to the date of this revocation/termination will not be affected by this revocation/termination request.

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\_\_\_\_\_  
Signature of Individual

\_\_\_\_\_  
Date

or

\_\_\_\_\_  
Signature of Personal Representative

\_\_\_\_\_  
Date

If a Personal Representative executes this form, that Representative warrants that he or she has authority to sign the authorization form on the basis of:

A signed Personal Representative Form;

Other: \_\_\_\_\_

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Acknowledgement by the Privacy Officer: \_\_\_\_\_ Date: \_\_\_\_\_, 20\_\_

*Once completed, please return this form to the:*  
Privacy Officer for Flagstaff Unified School District #1  
3285 E. Sparrow Ave., Flagstaff, AZ 86004  
Phone: 928/527-6046 Confidential fax #: 928/527-6065

## Flagstaff Unified School District #1 Form to Appoint a Personal Representative

Complete the following chart to indicate the name of the proposed Personal Representative

	Plan Participant:	Proposed Personal Representative:
<b>Name (print):</b>		
<b>Address (City, State, Zip):</b>		
<b>Phone:</b>	(    )	(    )
<b>IMPORTANT: Insert the Personal Representative's Password for Telephonic Identification:</b>		

I, \_\_\_\_\_ [*Name of Participant or Beneficiary*] hereby designate  
 \_\_\_\_\_ [*Name of Personal Representative*]:

to act on my behalf,

to act on behalf of my dependent child(ren) named:  
 \_\_\_\_\_

in receiving:

- a. any Protected Health Information (PHI) that is (or would be) provided to me as a participant/beneficiary of the Plan, including any individual rights that I have regarding my PHI under HIPAA.
- b. only the following Protected Health Information to conduct the following functions on my behalf:  
 \_\_\_\_\_.

I understand that this designation of a Personal Representative is subject to approval by the Plan. I also understand that, once approved, this designation will remain in effect unless I revoke it. I understand that I have the right to revoke this designation at any time by completing a form to Revoke a Personal Representative available from the Privacy Officer. I understand that I may review a copy of the Plan's Policy on Personal Representatives.

\_\_\_\_\_  
 Participant or Beneficiary's Signature

\_\_\_\_\_  
 Date

\_\_\_\_\_  
 Personal Representative's Signature

\_\_\_\_\_  
 Date

The above Personal Representative request is:

approved.

not approved because: \_\_\_\_\_

Privacy Officer: \_\_\_\_\_ Date: \_\_\_\_\_, 20\_\_\_\_

*Once completed, please return this form to the:*  
 Privacy Officer for Flagstaff Unified School District #1  
 3285 E. Sparrow Ave., Flagstaff, AZ 86004  
 Phone: 928/527-6046 Confidential fax #: 928/527-6065

## Flagstaff Unified School District #1

### Form to Revoke a Personal Representative

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Complete the following chart to indicate the name of the Personal Representative to be revoked:

	Plan Participant:	Person to be Revoked as my Personal Representative:
<b>Name (print):</b>		
<b>Address (City, State, Zip):</b>		
<b>Phone:</b>	(    )	(    )

I, \_\_\_\_\_ (Name of Participant or Beneficiary)  
 hereby revoke the authority of \_\_\_\_\_ (Name of Personal  
 Representative)

to act on my behalf,

to act on behalf of my dependent child(ren), named:

\_\_\_\_\_,  
 in receiving any Protected Health Information (PHI) that is (or would be) provided to a personal representative,  
 including any individual rights regarding PHI under HIPAA, effective \_\_\_\_\_,  
 20\_\_\_\_.

I understand that PHI has or may already have been disclosed to the above named Personal Representative prior to  
 the effective date of this form.

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Participant or Beneficiary's Signature

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Date

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Acknowledgement by the Privacy Officer: \_\_\_\_\_ Date: \_\_\_\_\_, 20\_\_\_\_

*Once completed, please return this form to the:*  
 Privacy Officer for Flagstaff Unified School District #1  
 3285 E. Sparrow Ave., Flagstaff, AZ 86004  
 Phone: 928/527-6046 Confidential fax #: 928/527-6065