

Note: Any covered participant over the age of 18 requires a separate Authorization Form to be completed.

Section A – Individual Authorization Use and/or Disclosure of Protected Health Information (PHI)			
Participant Name			
Mailing address			
City, State, Zip Code		Telephone	
Social Security # or Your Participant ID # as assigned by WageWorks			
Section B – Statement of Revocation			
<p>I revoke my previous authorization for your use and/or disclosure of my protected health information (PHI) as described below.</p> <p>I understand that this revocation of my authorization will NOT affect any action you or others took in reliance on my authorization before they received this written notice of my revocation.</p> <p>Copy of authorization attached: <input type="checkbox"/> Yes <input type="checkbox"/> No</p>			
Section C – Description of Authorization Revoked (Complete this section if authorization NOT attached)			
<p>Date of authorization (if known) ____/____/____</p> <p>Protected Health Information: <i>The revoked authorization authorized use and/or disclosure of the following PHI.</i></p>			
<p>Entities or Persons Authorized to Use or Disclose: <i>The revoked authorization authorized the following persons and/or organizations (or classes of persons and/or organizations), including us, to make use of or to disclose the protected health information described above.</i></p>			
<p>Entities or Persons Authorized to Receive and Use: <i>The revoked authorization authorized the following persons and/or organizations (or classes of persons and/or organizations), including us, to receive and/or use the protected health information described above.</i></p>			
Section D – Individual's Signature			
<p>Print Name: _____</p> <p>Signature: _____ Date: _____</p>			
<p>If this revocation is signed by a personal representative on behalf of the individual, complete the following:</p> <p>Personal Representative's Name: _____</p> <p>Signature: _____ Date: _____</p> <p>Relationship to Individual: _____</p>			

AFTER YOU HAVE SIGNED THE AUTHORIZATION, KEEP A COPY FOR YOUR RECORDS.

Submit to: **WageWorks, Inc.**
Claims Administrator
PO Box 14053
Lexington, KY 40512

Fax: **(866) 672-3703**