

END AUTHORIZATION TO SHARE HEALTH INFORMATION

If you want Health Tradition to stop sharing your health information with a person or agency that you authorized in the past, complete the **End Authorization to Share Health Information** form.

INSTRUCTIONS FOR COMPLETION

1. Print or type.
2. Use blue or black ink.
3. **Individual's Name:** Your name or your dependent's name.
4. **Birth date:** Your birthdate or your dependent's birthdate.
5. **Subscriber Number/Group Number:** Your (or your dependent's) Health Tradition subscriber number and group number.
6. **End Authorization:** Who is the person or agency that should no longer receive your health information?
7. **Individual's Signature:** The person from #3 must sign the form.
 - If a dependent is under 18, the parent/legal representative must sign the form.
 - If an adult cannot sign the form, the parent/legal representative must sign the form and write why they are signing (disability or health condition).
8. **Date:** What date are you signing the form?
9. Send the form to:

Health Tradition
Attn.: Office of General Counsel
45 Nob Hill Road
Madison, WI 53713-3959

Fax: (833) 552-0028, Attn.: Office of General Counsel

END AUTHORIZATION TO SHARE HEALTH INFORMATION

Individual's Name: _____ **Individual's Birth Date:** _____

Subscriber Number: _____ **Group Number:** _____

End Authorization

I want Health Tradition to stop sharing my health information with: _____

I understand that I gave Health Tradition permission to share my health information with this person or agency in the past. I cannot change any information Health Tradition shared before receiving this form.

Individual's Signature

Date

Send the form to:

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