Substance Use Disorder

Revocation of Release of Confidential Information

Name:		Medicaid ID:			
Phone:		DOB:			
Address:					
City:		State:		Zip Code:	

I hereby revoke the authorization of release of confidential information previously provided to Virginia Premier Health Plan. Any additional disclosures of information that relate to my substance use disorder treatment must be reauthorized.

Signature:		Date:	
If the information you are requesting to be disclosed is not about you or your minor child, please complete the section below. If you are a legal representative of the person whose information you are requesting, you must provide documentation proving your legal authority to request this information (for example: power of attorney, guardianship papers, health care surrogate form, etc.).			
Legal Representative Signature:			
Legal Representative Printed Name:			
Relationship of Representative:		Date:	

Please send completed form to Health Services
Fax # (877) 289-9381
Phone # (800) 727-7536