



**STATE EMPLOYEE HEALTH PLAN (SEHP)
Revocation of Personal Representative**

Appendix S1

Member Information		
Member, Spouse or Dependent Names <small>(LAST, FIRST, MI)</small>	Mailing Address <small>STREET ADDRESS CITY, STATE, ZIP</small>	Phone Number <small>Including Area Code</small>
Member ID number or Social Security Number		

Personal Representative Information			
Personal Representative NAME (LAST, FIRST, MI)	Mailing Address <small>STREET ADDRESS CITY, STATE, ZIP</small>	Phone Number <small>INCLUDING AREA CODE</small>	Relationship to the Member

I, the above named member, hereby revoke the above named person, to:

- Act on my behalf or,
- Act on behalf of my covered spouse / dependent(s) named below:

Name	Name
Name	Name

I revoke the designation of Personal Representative for the above named individual in receiving any protected health information (PHI) that is or would be provided to me as a member / beneficiary of the SEHP, including any individual rights that I have regarding my PHI under the Health Insurance Portability and Accountability Act (HIPAA) effective

I understand that PHI has or may already have been disclosed to the above named Personal representative in accordance with the previous appointment and **prior** to the effective date of this revocation.

Member's Signature	Date
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