First MEDICAL HEALTH PLAN, INC.

REQUEST FORM FOR REVOCATION OF USE AND/OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

You have the right to revoke a prior authorization to use and disclose your Protected Health Information at any time by completing the Form. The revocation will be in effect for future uses and disclosures and will not affect the uses and disclosures permitted by your authorization while the revocation was in effect. Unless you provide us with a new written authorization after making a revocation, we may not use or disclose your Protected Health Information for any other reason.

You may submit your request by addressing it to **First Medical Health Plan, Inc.'s Chief Compliance and Privacy Officer** at **PO Box 191580, San Juan, PR 00919-1580**, by email at cumplimiento@firstmedicalpr.com, facsimile 787-300-3913 or by delivering it directly to any of First Medical Health Plan, Inc.'s Service Offices.

I. Beneficiary/Subscriber Information:		
Name:	Middle name:	Surnames:
Date of Birth (*Month/Day/Year*):		Plan Identification Number/Contract Number:
Address:		
Main Phone:		Alternate Phone:
Email:_____		
☐ I authorized First Medical to send information to my email in a secure (*Encrypted*) manner.		
II. Declaration of Revocation		
I hereby revoke the authorization previously granted for the use and disclosure of my Protected Health Information to the following person or organization		
III. Name of Person or Organization/Relationship to Beneficiary/Subscriber:		
_____ _____ _____		
IV. Validity		
This revocation of use and/or disclosure shall be effective as of the date:_____		
V. Signature		
Beneficiary/Subscriber Signature:		Date:

If you are a Legal Representative of the Beneficiary/Subscriber, you must:

1. Indicate your full name: _____
2. Describe your authority to act for the Beneficiary/Subscriber (e.g., power of attorney, court order, or medical certification) _____
3. Provide a copy of the legal document that appoints you as Legal Representative. A Social Security proxy document is not admissible for purposes of this form (please request assistance from a Customer Service Representative).

Signature of the Legal Representative: _____Fecha: _____

For Exclusive Use of FMHP Compliance Department-Privacy Unit

☐ Application Accepted
☐ Application Denied Reason: _____
☐ Beneficiary/Subscriber Notified Date: _____

If you need additional information, please contact First Medical Health Plan, Inc.'s Privacy Unit at 787-474-3999, extension 2108/2583. We are available Monday through Friday from 8:00 a.m. to 5:00 p.m.

The Customer Service Department offers free language interpreter services and sign language. This includes services in alternate formats such as Braille, large print, and translation to other languages, verbally or written, among others. If you need plan information in another format or language, please contact our Customer Service Department at the number on the back of your plan card.

El Departamento de Servicio al Cliente ofrece servicios de intérprete de idiomas y lenguaje de señas libre de costo. Esto incluye, servicio de formatos alternos tales como: Braille, letra agrandada y traducción a otros idiomas, verbal o escrito, entre otros. Si usted necesita información del plan en otro formato o lenguaje, por favor comuníquese con nuestro Departamento de Servicio al Cliente al número que aparece al dorso de su tarjeta del plan.

First Medical cumple con las leyes federales aplicables de derechos civiles y no discrimina en base a raza, color, origen de nacionalidad, edad, discapacidad, o sexo. **First Medical** complies with applicable federal civil rights laws and does not discriminate based on race, color, national origin, age, disability, or sex.

First Medical 遵守適用的聯邦民權法律規定，不因種族、膚色、民族血統、年齡、殘障或性別而歧視任何人.