ALAMEDA COUNTY EMPLOYEES' RETIREMENT ASSOCIATION

475 – 14TH STREET, SUITE 1000, OAKLAND, CA 94612   1-800-838-1932   510-628-3000   FAX: 510-268-9574

CANCELLATION OF HIPAA AUTHORIZATION FORM

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Your Name (Please Print)

I hereby cancel any existing HIPAA Authorization Form that allows ACERA to provide my Protected Health Information ("PHI") to the following person(s) or entity(s): (please fill in the name and address of the appropriate person(s) or entities)

☐ **Person** : ____

Address: ____________________________ City: ___________________State: _____ Zip: _______

☐ **Entity** : ____

Address: ____________________________ City: ___________________State: _____ Zip: _______

I understand:

- **THIS FORM REVOKES ANY PREVIOUS HIPAA AUTHORIZATION FORM ONLY WITH RESPECT TO THE PERSON(S) OR ENTITIES NAMED ABOVE. IF I DECIDE TO REAUTHORIZE THE RELEASE OF MY PERSONAL HEALTH INFORMATION TO ANY ENTITY OR PERSON, I WILL NEED TO SUBMIT A NEW COMPLETED HIPAA AUTHORIZATION FORM TO ACERA.**
- **CANCELLATION WILL TAKE EFFECT ONCE ACERA RECEIVES THIS FORM.**

____ ____________________

Your Signature **Date**

(or Signature of Personal Representative*)

____

Print Name

Note: **If you are acting as the Personal Representative*

**If you are acting as the Personal Representative of the individual whose PHI is to be disclosed, you must provide proof of your authority to act for that individual. ACERA will verify if documentation of proof is on file. If this documentation is not on file, you will be asked to provide it.*

(A copy of this Cancellation of Authorization Form will be sent to you or your Personal Representative.)

For Office Use Only*

Input by: _________ Date: ________

Verified by: _________ Date: ________

05/18/2007