WELL SENSE HEALTH PLAN

wellsense.org | 877-957-1300

Well Sense Health Plan Revocation of Release of Information

Please Note: This form is used to revoke the person or the organization authorized to receive your protected health information. By doing so, the person or the organization will no longer receive information in regards to your health care provided by Well Sense Health Plan. All fields are required. Incomplete or incorrect forms will be returned.

Member Information (Please print information clearly)			
YOUR MEMBER ID NUMBER (FOUND ON YOUR WELL SENSE HEALTH PLAN ID CARD)			
MEMBER'S LAST NAME			
FIRST NAME	MIDDLE INITIAL		
ADDRESS	CITY	STATE	ZIP CODE
PHONE			

Recipient (person or organization that received your information)	
I hereby revoke my previous request to release my Protected Health Information to:	
PERSON'S NAME OR ORGANIZATION (PLEASE PRINT)	PHONE
ADDRESS (INCLUDING ZIP CODE)	

I understand that my revocation of my authorization of the Release of Information will be effective upon receipt and processing of my written revocation and that the revocation will not be valid where Well Sense Health Plan has already acted in reliance upon my authorization.

Member's Signature Date

****WELL SENSE HEALTH PLAN USE ONLY****	
REQUEST RECEIVED : ☐ BY PHONE ☐IN WRITING	DATE (MM/DD/YYYY)

Mail or Fax completed form to:

Well Sense Health Plan
Attention: Privacy Officer
1155 Elm Street, Suite 600
Manchester, NH 03101

Fax: 617-897-0884