

Thrive Iowa Request to End an Authorization

Name	Date of Request
Mailing Address	City, State, and ZIP Code
Phone Number	Birth Date

To be completed by the client or the client’s personal representative

Please select one option below regarding how you would like to end your authorization for the Thrive Iowa initiative:

- ☐ **Revoke all access**
I request to end *all* authorization previously granted. This revocation will stop all individuals, providers, and organizations from receiving or using my information under the Thrive Iowa initiative.
- ☐ **Revoke access for specific people or organizations**
I request to end authorization **only for the specific individuals, providers, or organizations listed below.**
(Provide names or organizations):

I understand that this request is not effective until the Department receives it. I also understand that this request to end the authorization cannot apply to any action the Department or other participating organizations or individuals have already taken on the authorization before this date.

Name of person signing	Relationship to client ☐ Self ☐ Personal representative ☐ Other authority of person signing (e.g., 42 CFR §§ 2.14, 2.15)
Client or Personal Representative’s Signature	Date

Instructions

Submit the signed form to Thrive@hhs.iowa.gov.