



Request to End an Authorization

Name of Client	Date of Request	
Mailing Address – Street or PO Box	Social Security Number, Patient Number, or State ID	
City, State, and Zip Code	Phone Number	Birth Date
Check all of the programs that apply: <input type="checkbox"/> Medicaid <input type="checkbox"/> Hawki <input type="checkbox"/> Facility		
To be completed by the client or the client’s personal representative		
<p>I request that the authorization I signed to release health care information to (name of person or organization) _____ dated _____ be stopped.</p> <p>I understand that this request to end the authorization cannot apply to any action the Department has already taken on the authorization before this date.</p>		
Client or Personal Representative’s Signature	Date	