IOWA Health and Human Services

Request to End an Authorization

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

Check all of the programs that apply:

- ☐ Medicaid
- ☐ Hawki
- ☐ Facility
  - ☐ Cherokee MHI
  - ☐ Independence MHI
  - ☐ Woodward Resource Center

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

I request that the authorization I signed to release health care information to be stopped. I understand that this request is not effective until the covered entity receives it. I also understand that this request to end the authorization cannot apply to any action the Department has 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