



AMERICAN MARITIME OFFICERS (AMO) PLANS

2 West Dixie Highway, Dania Beach, FL 33004
Tel: (954) 920-4247 (800) 348-6515 Fax: (954) 920-9482 www.amoplans.com



CANCELLATION OF AUTHORIZATION FOR DISCLOSURE OF PROTECTED HEALTH INFORMATION (PHI)

REQUIRED INFORMATION		
Participant Name:	SSN: XXX-XX-	DOB:
Street Address:		
City:	State:	ZIP Code:
Your Name:	SSN: XXX-XX-	DOB:
Street Address:		
City:	State:	ZIP Code:
Relationship:		

AUTHORIZATION		
I hereby revoke the Authorization granting the American Maritime Officers (AMO) Medical Plan permission to disclose my Protected Health Information ("PHI") to the following person:		
Name:	Relationship:	
Address:		
City:	State:	ZIP Code:

SIGNATURE	
I understand that this Cancellation will not become effective until it is received and logged by the Privacy Officer of the AMO Medical Plan.	
Participant Signature:	Date:
* If you are signing as the Personal Representative of the person whose PHI is to be disclosed, you must enclose documented proof of your authority to act for that person (i.e Power of Attorney, Letters of Guardianship.) Please note that the documentation must specifically include health care purposes. You may mail or fax the completed and signed Authorization to the Privacy Officer at the address listed above.	

NOTARY PUBLIC		
STATE OF _____) COUNTY OF _____)		
The foregoing instrument was acknowledged this _____ day of _____, 20____, by _____ (print name of participant), who personally appeared before me and acknowledged that he/she signed the instrument voluntarily for the purpose expressed in it.		
Signature of Notary Public _____ Print, Type, or Stamp Commissioned Name of Notary Public _____ Date Commission Expires _____	NOTARY SEAL	<input type="checkbox"/> Personally Known <input type="checkbox"/> Produced Identification Type of Identification: _____