



I, \_\_\_\_\_ understand that by signing this form, I am confirming my revocation that the Prescription Drug Plan administrator may no longer use and/or disclose my protected health information to the person and/or organization named in this form.

**Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

If the person signing this form is not the member, or the parent/guardian of a dependent under the age of 18, you must attach a full copy of the official document indicating your legal authority to sign on behalf of the member (i.e. Power of Attorney, Court Assigned Guardian, Personal Representative, etc.)

If you need help completing this form, please call Medi-CareFirst toll free at 1-888-857-6118 from 8 am to 8 pm, 7 days a week, TTY/TDD users should call 1-800-855-2880.

Please mail or fax this authorization to: **Medi-CareFirst BlueCross BlueShield**  
**Membership Customer Service**  
**c/o CGI, Inc.**  
**P.O. Box 8100**  
**Lancaster, SC 29721**  
Fax: 1-888-524-6787

**Please keep a copy of the designation.**  
**We will provide you with a signed copy of this designation upon request.**

If the records are so protected, Federal Regulation (42 CFR Part 2) prohibits the recipient of the information from making any further disclosure of this information unless such disclosure is expressly permitted by the written consent of the person to whom it pertains, or as otherwise permitted by 42 CFR Part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

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