

Iowa Department of Human Services

REQUEST TO END AN AUTHORIZATION

Name of Client		Date of Request	
Mailing Address – Street or P.O. 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"/> <i>hawk-i</i> <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	