**St. Luke's Health Plan, Inc.**
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Seattle, WA 98111-9110
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# Cancellation of Authorized Representative

To cancel a previous approval of an Authorized Representative, please fill out all the information below and return it to us. If you cancel your Authorized Representative, we will stop sharing any and all information with that person.

**Member Name** (First/Last): ________________________________

**Member ID #:** ________________________________________

**Member Date of Birth** (Month/Day/Year): ______________________

I hereby revoke any previous approval(s) of the person below to act as my Authorized Representative:

**Name of Previously Designated Representative:** _______________________________________________

**Street Address:** _______________________________________________________________

**City, State, Zip Code:** _______________________________________

**Telephone Number:** _______________________________________

This cancellation will be effective as soon as possible after receipt of this form by St. Luke's Health Plan.

**Signature:** __________________________________________________ **Date**: _______________________

Relationship to Member: Self Parent Legal Guardian Power of Attorney