

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. If your enrollment is through the exchange, you will need to update your designation authorization by contacting Your Health Idaho directly.

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