

## Designated Representative Revocation Form

**INSTRUCTIONS:** This form may be used by a WTC Health Program member or applicant to revoke (remove) their previous appointment of a Designated Representative. If you choose to submit this form, it must be filled out in its entirety by the WTC Health Program applicant or member. If you are interested in revoking your previous designated representative appointment, you may submit only this form. If you are interested in changing your designated representative, the Designated Representative Appointment and HIPAA Authorization for Designated Representatives Forms (or their equivalent) would also need to be submitted.

**Please return all documents to the WTC Health Program via mail ATTN: WTC Health Program Privacy Officer at P.O. Box 7000 Rensselaer, NY 12144 or via fax at 404-448-4485.**

I, \_\_\_\_\_, want to withdraw my appointment of  
(NAME OF APPLICANT/MEMBER)

\_\_\_\_\_ as my designated representative for purposes  
(NAME OF DESIGNATED REPRESENTATIVE)

of the WTC Health Program, meaning that they will no longer be able to make requests or give direction to the WTC Health Program on my behalf regarding administrative matters.

I also want to revoke the HIPAA Authorization I submitted allowing the WTC Health Program to disclose my protected health information to the above individual acting as my Designated Representative, including protected health information contained in medical, treatment, and diagnostic records.

I understand that any use or disclosure of information by the WTC Health Program made prior to the Program's receipt of my written request to revoke this authorization will be governed by the previous authorization to the extent that the Program has taken any action in reliance on it.

\_\_\_\_\_  
**Printed Name of Applicant/Manager**

\_\_\_\_\_  
**Date of Birth**

\_\_\_\_\_  
**Address**

\_\_\_\_\_  
**WTC Health Program ID (911#), if known**

\_\_\_\_\_  
**Address Line 2**

\_\_\_\_\_  
**Phone**

\_\_\_\_\_  
**Applicant/Manager Signature**

\_\_\_\_\_  
**Date**

Public reporting burden of this collection of information is estimated to average 15 minutes per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. An agency may not conduct or sponsor, and a person is not required to respond to a collection of information unless it displays a currently valid OMB control number. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden to CDC/ATSDR Information Collection Review Office, 1600 Clifton Road NE, MS D-74, Atlanta, Georgia 30333; ATTN: PRA (0920-0891).