Acumen Fiscal Agent
Innovation • Opportunity • Freedom

Please return form to NCMCOAgents@acumen2.net

WITHDRAWAL OF AUTHORIZATION TO OBTAIN/DISCLOSE PROTECTED HEALTH INFORMATION

As of this date, _____, I withdraw this Authorization to Obtain/Disclose Protected Health Information.

I understand that no further releasing of information may occur (based on this Authorization). However, I understand that when I revoke this Authorization, it will have no effect on actions taken by Acumen Fiscal Agent prior to the date it was revoked or received (whichever is later).

_____ _____
Employer Signature Date

_____ _____
Participant Signature (If applicable) Date