ARKANSAS WORKS REGISTERED REPORTER REVOCATION FORM

COMPLETE ONLY WHEN REVOKING THE AUTHORIZATION

Enrollee/Member Information

Enrollee/Member Name (*Last, First Middle*)	Enrollee/Member Date of Birth	Enrollee/Member Medicaid Number
Enrollee/Member Address	Enrollee/Member Phone Number	Enrollee/Member E-mail Address

Registered Reporter Information

Reporter Name (*Last, First Middle*)	Reporter Phone Number	Reporter E-mail Address

I do hereby request that the authorization to the Register Reporter listed above to report my Arkansas Works (AR Works) work and community engagement activities or exemption, which included authorization to inspect and/or receive confidential health and work-related information for the limited purpose of reporting the AR Works work and community engagement or exemption, be rescinded, effective _____.

(Enter Date of Signature)

I understand that any action taken on the authorization prior to the date this form is signed is legal and binding.

I understand that upon revocation it is my responsibility to reset my password or login credentials on the portal (https://www.access.arkansas.gov/).

_____

Enrollee/Member Signature

_____

Date

*This form must be scanned and emailed to AWREPORTER@dhs.arkansas.gov and retained by the Enrollee/Member and registered reporter