advent PHYSICAL THERAPY

NOTIFICATION TO REVOKE A PREVIOUS AUTHORIZATION

Patient Name: _____Med Rec / Account #_____
Date of Birth: _____

USE THIS FORM TO REVOKE AN AUTHORIZATION PREVIOUSLY GIVEN

Section A: Individual revoking authorization - Please complete the following information:
NAME _____
DAYTIME PHONE NUMBER_____
ADDRESS_____
CITY STATE ZIP_____

Section B: Revocation

□ I revoke my authorization for use and disclosure of my Protected Health Information (PHI) described in my original authorization.

I understand that this revocation *will not* affect actions taken in accordance with my original authorization prior to receipt of this written revocation.

Section C: Signature

Patient's Signature: _____ Date: _____
Print Name:_____**(when patient is a minor, or is not competent to give consent, the signature of a parent, guardian, or other legal representative is required).**

Signature of Legal Representative: _____ Date: _____
Print Name of Legal Representative: _____
Description of Legal Representative Authority: □ Parent □ Medical Power of Attorney (attach documentation)
□ Other _____ (Explain and Attach Documentation)

Signature must be verified by Provider staff OR must be notarized. When completed, please place in patient record.

_____	_____	_____
Signature of staff member	**Print Name**	**Date**

SUBSCRIBED AND SWORN before me this _____day of _____, 20_____.
My commission expires:

_____
Notary Public Signature

For Internal Use Only

Information Released/Reviewed By: _____ Date: _____
Clinic/Office: _____