**Revocation of Authorization for Release of Protected Health Information**

The HIPAA Privacy Rule gives you the right to revoke an authorization at any time. This revocation will not apply to releases performed under the original authorization.

1. Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 2. Company: Choose an item.
2. Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
3. DOB: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 4. Medical Record Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I revoke my authorization for use and disclosure of my Protected Health Information (PHI) with:

Name of Person or Organization: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name of Person or Organization: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

By signing below, I understand and agree that:

* This revocation is voluntary.
* I may not be denied treatment if I do not sign this form.
* Cancellation of my previous authorization is effective on the date my request is processed.
* This revocation *will not* affect actions taken in accordance with my original authorization prior to receipt of this written revocation.

Signature of Patient / Patient Representative: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If this request is being signed by the patient’s legal representative, you must provide legal documentation authorizing you to act on the patient’s behalf (e.g. legal guardianship, power of attorney, personal representative).

If you are making this request on behalf of a minor child, we may require additional information before processing this request.

F**OR HEALTHCARE ORGANIZATION USE ONLY**

**□ Revocation recorded in patient chart**

**Signature of Privacy Official: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**