Connect for Cancer Prevention Study

Revocation of HIPAA Authorization Form

By completing this form you are requesting a restriction to any further uses and disclosures (releases) of your protected health information.

I understand that by signing electronically below, I am revoking (taking back) previous authorizations to use and disclose my protected health information for the Connect for Cancer Prevention Study. I understand that this revocation only applies to future uses and disclosures of my protected health information and will not affect any uses and disclosures that any of the clinics, hospitals, or other health care providers that I use, directly or by an entity on its behalf, have already made in reliance of my authorization before receiving this written notice of revocation.

Please enter your legal name. If you are a member of Kaiser Permanente, please enter your first and last name exactly as it appears on your Kaiser Permanente ID card.

Print Name:

Signature:

Date:

Version 1.0