

AUTHORIZATION REVOCATION



PURPOSE: This form is used to revoke or to confirm revocation of an authorization previously given

SECTION A: Individual revoking the authorization.

Name: _____

Address: _____

Telephone: _____ E-mail: _____

Identification Number: _____ Social Security Number: _____

TO THE INDIVIDUAL: Please read the following and complete the information requested.

I revoke my authorization for the use and/or disclosure of the protected health information described in the authorization (or as described in Section B, if the authorization is not attached).

I understand that this revocation will *not* affect any action you or others took in reliance on my authorization before receipt of this written revocation. I also understand that, if my authorization was a condition of my enrollment in a health plan, of my eligibility for benefits, or if my receipt of health care is to create protected health information for a third party, you may disenroll me from the health plan, end my eligibility for the benefits, or not provide for the health care.

Copy of authorization attached: Yes. No (complete Section C).

SECTION B: Description of authorization revoked (complete if authorization not attached).

Date of authorization (if known): ____/____/____

Protected Health Information Affected: The revoked authorization applied to the following protected health information:

Entities Authorized to Use or Disclose: The revoked authorization allowed use and/or disclosure of the protected health information described above by the following persons and/or organizations (or classes of persons and/or organizations), including us:

Entities Authorized to Receive and Use: The revoked authorization allowed the protected health information described above to be received and used by the following persons and/or organizations (or classes of persons and/or organizations), including us:

INDIVIDUAL'S SIGNATURE.

Signature: _____ Date: _____

If this revocation is signed by a personal representative on behalf of the individual, complete the following:

Personal Representative's Name: _____

Relationship to Individual: _____

YOU ARE ENTITLED TO A COPY OF THIS AUTHORIZATION REVOCATION AFTER YOU SIGN IT.

**Include completed form in the individual's records.
Send copy to the Privacy Official.**