AUTHORIZATION REVOCATION

(This form is used to revoke or to confirm the revocation of a medical records authorization previously given.)

Section A: Individual Revoking the Authorization.

Name of Patient: _____ Date of Birth: _____

Address: _____Telephone: _____

Section B: Statement of Revocation.

I revoke my previous authorization for your use and disclosure of my health information as described below.

I understand that this revocation of my authorization will not affect any action you or others took in reliance on my authorization before receipt of this written notice.

Description of Authorization Revoked.

Date of Authorization: _____/_____/_____

Description of Health Information: _____

_____

Entities Authorized to Use or Disclose: The previous authorization authorized the following persons and/or organizations (or classes of persons and/or organizations), including us, to make use of or to disclose the health information described above: _____

_____

Entities Authorized to Receive and Use: The previous authorization authorized the following persons and/or organizations (or classes of persons and/or organizations), including us, to receive and or use the protected health information described above: _____

_____

Signature of Patient: _____ Date: _____

Name of Personal Representative (if applicable): _____Relationship: _____

Signature of Personal Representative: _____ Date: _____

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