

Revocation of Authorization of Protected Health Information

PATIENT INFORMATION

Last Name	First Name	
Address		
City	State	Zip Code
Phone Number	Date of Birth	

I hereby request _____ to revoke/cancel
Clinic Name

The current authorization on file, which permits the following person(s) or entity listed below to access my protected health information:

Name	Relationship

SIGNATURE REQUIRED

- ♦ I understand that signing and submitting this form ends my previous authorization to release information to the individual(s) or entity listed above.
- ♦ I understand that this revocation will be effective three (3) business days after receipt of this form.
- ♦ I understand that the revocation **will only apply to further disclosures or actions** regarding my protected health information and does not cancel actions or disclosures made while the disclosure was previously in effect and valid.
- ♦ I will retain a copy of the revocation form for personal reference, and the original will be kept on file in the medical record for the period of time designated for such retention.

Print Name:	Date
Signature:	
*Name of Interpreter/Translator (if required)	Phone Number

OFFICE USE ONLY

Office Personnel (Print Name)	Date
-------------------------------	------