Revocation of an Authorization

Name of Resident: _____ Date: _____

I hereby request that the following authorization(s) be revoked as of _____

[ ] Authorization for Use or Disclosure of Protected Health Information dated: _____

[ ] Request to Restrict the Use and Disclosure of Protected Health Information dated: _____

[ ] Request for Amendment/Correction of Protected Health Information dated: _____

[ ] Request for Inspection/Copy of Protected Health Information dated: _____

[ ] Request for Restriction of Confidential Communications dated: _____

[ ] Request for an Accounting of Disclosures of Protected Health Information dated: _____

[ ] Other (specify)_____ dated: _____

[ ] Other (specify)_____ dated: _____

I understand that the revocation of authorizations I have checked will not apply to any actions already taken by the facility in reliance on such authorizations to use or disclose my protected health information.

Date: _____ Signature of Resident: _____

Printed Name: _____

Date: _____ Signature of Representative: _____

Printed Name: _____

Relationship to Resident: _____

Comments:

Facility Response to Request

Your revocation notice has been received. No further releases, unless permitted by current privacy laws, will be made of your protected health information until you provide the facility with written authorization to release such information.

Date: _____ Signature/Title of Facility Representative: _____

A copy of this record must be provided to the person making the request and a copy must be filed in the medical record.