REQUEST TO REVOKE AN AUTHORIZATION

Purpose: This form is used to revoke or to confirm revocation of a previously authorized disclosure. You may make this revocation at any time by giving written notice to a Privacy Contact listed on our Notice of Privacy Practices. You may only revoke an authorization you made for yourself or your minor child. This revocation of authorization will not affect any action we took in reliance on the initial authorization prior to receiving this notice.

Patient Name: _____ Date of Birth: ____-____-____

Address: _____ Telephone Number: ( ) _____-_____

_____ Email: _____

Person's Name Requesting Revoke (if different than patient): _____

Check all that apply:

Relationship to the patient: ☐ Legal Guardian ☐ Parent ☐ Executor ☐ POA

Patient is: ☐ Minor ☐ Legally Incompetent ☐ Deceased

☐ I _____, revoke my authorization for the use and/or disclosure of the protected health information described below. If available, a copy of the original authorization should be attached. Date of Original Release: _____-_____-_____

Revoke release to: _____ (facility/person)

PRA clinician chart: _____

I understand that PRA or Associates may have already made disclosures based on my earlier authorization and so these disclosures cannot be recovered or undone. I hereby release this clinician and PRA from any legal responsibility or liability for disclosing the information I authorized previously. I also understand that some disclosures are required by law in some cases and I cannot revoke their release.

Signature of patient: _____ Date: _____-_____-_____
(12 & older)

Signature of Legal Representative: _____

Printed Name of Legal Representative: _____

Relationship to the patient: _____

Received by: _____ Date: ____-____-____

Revoked by: _____ Date: ____-____-____

Release Restriction applied/notes in EMR ☐