[Company Name]

Revocation of Authorization for Use and Disclosure of Protected Health Information

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1. Revocation of Authorization

This notice revokes the authorization to the use and disclosure of protected health information for:

_____
Patient Name (Please Print or Type)

that was signed on:

_____
Date of Consent

2. Effect of Revocation

Protected health information that is collected on or after the date on which this form is received by [Company Name] will not be used or disclosed by [Company Name] for the purposes specified in the authorization that is revoked.

This revocation of authorization will not limit the ability of [Company Name] to seek payment for services that it provided under an earlier authorization, nor to meet legal obligations related to those services, nor will it affect uses or disclosures under the revoked authorization that occurred prior to the effective date of this revocation.

Other consequences of revoking authorization include:

_____

_____

_____

_____

3. Effective Date of Revocation

This revocation of authorization to use or disclose protected health information is effective __/__/_____.

Signature

_____
Name of Patient (Print or Type)

_____
Signature of Patient

_____
Date

_____
Signature of Patient Representative

_____
Relationship of Patient Representative to Patient