

[Company Name]

Revocation of Consent to Use and Disclosure of Protected Health Information

1. Revocation of Consent

This notice revokes the consent to 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 no longer be used or disclosed by [Company Name] for the purposes of treatment or payment, or to support day-to-day health care operations of the practice as described in the authorization form.

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

It is the policy of [Company Name] that it will not continue to provide treatment for a patient who revokes consent to the use and disclosure of his or her protected health information for purposes of treatment, payment, or health care operations.

3. Effective Date of Revocation

This revocation of consent 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