



**PATIENT REVOCATION OF AUTHORIZATION TO DISCLOSE
PROTECTED HEALTH INFORMATION**



A previously signed Patient Authorization to Release Protected Health Information (PHI) form may be revoked at any time by completing this form. When referring to a previous Authorization, please be as specific as possible to ensure accuracy and that you are revoking the correct Authorization. You may request to view your previous Authorization forms, if needed, to complete the information requested below.

A revocation of authorization **cannot** be honored if Dean Clinic has taken action on or has relied on the Authorization in some manner.

Other regulations govern Authorizations which are signed as a condition of obtaining insurance coverage.

I understand that I am revoking an entire Authorization. If I still wish to authorize the release of PHI to certain parties, I must complete a separate Authorization form.

Patient Name: _____ Date of Birth: _____
Print Complete Name

In the previous release, I had authorized that medical information be released to:

(Name of Physician/Health Care Facility/Other)

(Street Address)

(City) (State) (Zip)

Date that I authorize release (if known): ____ / ____ / ____

I hereby revoke my prior authorization. I understand that this revocation is not effective for disclosures made based upon reliance of my prior Authorization.

(Signature of Patient) Date: _____

If this Authorization is signed by a representative of behalf of the patient, complete the following:

Representative's Name: _____

Relationship to Patient: _____

You are entitled to a copy of the "Revocation of Authorization" after you sign it.