PATIENT REVOCATION OF AUTHORIZATION
TO USE OR DISCLOSE PROTECTED HEALTH INFORMATION

Patient Name ____ **Medical Record #** ________________________________

Date of Birth ____ **Phone # (_______)**_______________________________

Patient Address____

____

Soc. Sec.# ____ **(Providing your SS# is voluntary, but necessary to accurately identify your medical records Failure to provide this information will likely delay the processing of your request).**

Approximate Dates of Treatment: ____

In my initial authorization, I authorized the following health care provider or facility **TO DISCLOSE** my patient information:

____

____

In my initial authorization, I authorized the following person or organization **TO RECEIVE** my patient information:

____

____

Revoke my authorization, dated: _____________________ **If this authorization was for RESEARCH, check here: _________.**

Disclose no more information to:

Name (or title) and organization: _______________________________________

Address: ______________________ City: __________ State: ____ Zip: ________

I understand that this request does not apply to any uses or disclosures:

- Before the UUHSC receives this revocation, or
- Allowed or required by law.

__________________________________ ____________
Signature of Patient or Representative Date

____
If Applicable, Name of Personal Representative*

*Description of Personal Representative Authority:

☐ Parent ☐ Medical Power of Attorney

☐ Other, explain: _______________________
and attach documentation.

Signature must be verified by U of U Health staff or notarization may be required. When complete, place in patient's medical record.

- ______________________________ Signature of UUHSC Staff Member ______________________________ Printed Name and Employee ID# _________ Date

- SUBSCRIBED AND SWORN before me this ____ day of ________________, 20____.

NOTARY PUBLIC

Residing in ________________________________

My Commission expires: _____________________

UUHSC Internal Use Only

☐ Staff Member Processing Request’s Name and Employee ID: ___________________________

☐ Date Received: ___________________________

☐ Original authorization identified.
☐ Individual or department sending patient’s protected health information notified of revocation.
☐ Individual or department receiving patient’s protected health information notified of revocation.

☐ Date Patient Notified: ___________________________