Revocation of HIPAA Authorization Form

Instructions: Use this form to revoke a previously signed HIPAA Authorization allowing the disclosure of your Protected Health Information (PHI). Once completed, print this form and deliver it to your healthcare provider or the entity holding your records.

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1. Patient Information

Patient Full Name: __________

Date of Birth (MM/DD/YYYY): __________

Phone Number: __________

Email Address: __________

Mailing Address: __________

2. Revocation Statement

I hereby revoke the authorization previously granted to release, use, or disclose my Protected Health Information (PHI) to the individual or organization specified below.

Name of Covered Entity (e.g., Hospital, Doctor, Clinic) originally authorized to release information:

____

Name of Recipient (Individual or Organization) originally authorized to receive the information:

____

Date the original authorization was signed (if known, MM/DD/YYYY): __________

3. Scope of Revocation

Please specify what this revocation applies to:

YES/NO Revoke ALL authorizations to release any and all of my PHI to the recipient named above.

YES/NO Revoke ONLY specific authorizations (please describe below):

Specify dates of service, specific records, or limitations here

4. Acknowledgement & Signatures

By signing below, I understand that:

- This revocation is effective upon receipt by the Covered Entity.
- This revocation will not apply to any actions already taken by the Covered Entity in reliance on my original authorization before they received this notice.
- This revocation will not affect any information that has already been disclosed.

Signature of Patient or Legal Representative: Sign name here when printed

Date (MM/DD/YYYY): __________

If Legal Representative, state relationship to Patient (e.g., Parent, Legal Guardian): __________