Adventist Health

REVOCATION OF AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION

Patient Name: _____ Birth Date: _____

Address: _____ Phone Number: _____

In accordance with the provisions of the Notice of Privacy Practices, I hereby revoke the:

☐ Authorization releasing information to:_____
☐ Authorization dated:_____

I understand that this revocation does not apply to any action Adventist Health has taken in reliance on the authorization I signed earlier. This revocation does not revoke any and all previous authorizations to release information that I have provided to Adventist Health.

Signature: _____ Date:_____Time: _____
(Patient/Legal Representative)

If signed by other than patient, indicate relationship:_____

Witness: _____

**********For Office Use Only**********

Medical Record Number: _____ Clerk's Initials: _____

Date Revocation Received:_____

☐ Identity of individual and/or legal representative verified

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Request for Restrictions for Use of PHI

PATIENT LABEL