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Revocation of Authorization to Disclose Health Information Form

This form is used to revoke previously authorized disclosure. The Health Insurance Portability and Accountability Act of 1996 (HIPAA) provides an individual the right to revoke a previous authorization to disclose protected health information at any time.

Patient Information:

Name: ______________________________________ D.O. B. ______/______/______

ID# or SSN: _________________________________ Phone #: ___________________

Statement of Revocation:

I hereby revoke any previous authorizations to disclose my protected health information (PHI)

I understand that this revocation of my authorization will only apply to further disclosures regarding my personal health information and cannot cancel actions or disclosures made before receiving this written notice of my revocation.

Description of Authorization Revoked:

Date of original authorization (if known): _____/_____/_____

Copy of authorization attached: Yes ___ No ___

Person or Entity authorized to receive the information:

____

Specific description of information to be revoked. (Information you authorized to be released)

____

____

This authorization must be signed and dated below by the patient or legal guardian to be valid. Parents or legal guardians must also include their name and relationship to the patient.

Patient Signature: ____ Date: ____/____/____

Parent/Legal Guardian Name: ____
(Please Print)

Legal Guardian Relationship to Patient: ____

Parent/Legal Guardian Signature: __________________________________ Date: ____/____/____

Please retain a copy of the revocation form for your records and a copy will be kept on file in your medical record for the time period according to Louisiana record retention law.