Springfield clinic

NOTICE OF REVOCATION OF AUTHORIZATION

I hereby revoke the prior authorization for the use or disclosure of my individually identifiable health information as described below.

Name of Patient (please print)	Date of Birth	Clinic Record Number

Maiden Name	Spouse's Name

The specific information, which I wish not to be disclosed, is as follows:

Any & all health information about me

The party or parties for whom the authorization is revoked - *This includes both written and verbal requests:*

_____

The revocation is effective this date: _____ (Date completed form received by Springfield Clinic)

It will expire this date: Upon receipt of written revocation by patient or patient's representative.

I understand that this revocation will not effect any actions that have been taken prior to the receipt of the revocation.

Signature of patient or patient's legal representative	Date

Printed name of patient's representative: _____

Relationship to patient: _____

Facsimile reproductions of the signature are acceptable.

Clinic Staff: Please forward this form to the Privacy Auditors at Main Campus HIM for processing.