Revocation of Authorization to Disclose My Health Information

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Patient name: _____ Date of birth: _____

I. My Revocation

I revoke my authorization to disclose my health information to:

Name (or title) and organization: _____

Address: _____ City:_____

State: _____ Zip: _____ Phone: _____Fax: _____

This revocation is effective:

☐ On (date) _____ ☐ When the following event occurs: _____

II. My Rights

I understand that I do not have to sign this authorization in order to get health care benefits (treatment, payment, or enrollment). However, I do have to sign an authorization form:

- To take part in a research study, or
- To receive health care when the purpose is to create health information for a third party.

My authorization will be revoked as stated above except to the extent that information or action has already been taken by Lori Birdsong, MD based upon previous authorization. I may not be able to revoke this authorization if its purpose was to obtain insurance.
Once the office discloses health information, the person or organization that receives it may re-disclose it. Privacy laws may no longer protect it.

_____ _____ _____

Patient or legally authorized individual signature Date Time

_____ _____

Printed Name if signed on behalf of patient Relationship (parent, legal guardian, personal representative, etc.)