Powell Valley Healthcare
Compassionate Quality Care

REQUEST TO REVOKE AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

Patient
Name_____Birthdate:_____MR#_____

Address:_____

Home Phone:_____ Work Phone:_____

I am requesting that the Authorization to Release Health Information Dated:_____ be revoked from this date and time forward.
I understand that this does not apply to any releases that have been done prior to this date in response to the previously mentioned Authorization.

_____
Additional comments:
_____

_____

_____

_____

Signature of Patient
Or Representative_____ Authority or Relationship
To Patient_____

Date Signed_____

Date Received_____

_____ _____
Signature of Privacy Officer Date