# Revocation of Authorization to Release Protected Health Information (PHI)

Your Rights - You have the right under HIPAA to cancel (revoke) permission you previously gave to Advocate Health to share (disclose) your health information with certain individuals or organizations. This is known as a revocation of Authorization for Release of Health Information.

Patient Name *(Please Print)* _____ Date of Birth _____ Phone Number _____

Street Address _____ City _____ State _____ Zip Code _____

**Revocation of Authorization to Release Protected Health Information**

I cancel (revoke) the Authorization to release information I provided to Advocate Health allowing disclosure of my PHI with the following individuals, organizations, or companies:

☐ All Active Authorizations for Release of Information on file (not already expired)

☐ Authorization(s) to share Health Information with: (list persons/organizations/companies & date of Authorization if known, below)

_____

_____

_____

I understand that:

1. Advocate Health cannot take back information it has already shared with others based on your previous Authorization.
2. You cannot revoke a disclosure that is required for the purpose of payment to Advocate Health for care provided, unless you pay the bill in full out of pocket.
3. This revocation does not stop disclosures required by law. If we are unable to locate the original authorization for which you are requesting a revocation, we will notify you.

**Patient/Legal Representative Signature:**_____**Date:** _____

If Legal Representative, indicate relationship to patient: _____

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***(For Internal Use)***

☐ Authorization(s) included in this request for revocation have already expired. No action necessary.

☐ Authorization(s) listed above, still in effect, has been annotated as "Revoked" and entered in the medical record along with this Revocation Form.

☐ Patient notified/letter sent.

Received by: _____ _____
Name/Department Date

Forward request as appropriate: ☐ Patient Financial Services/Business Office
☐ Imaging/Radiology
☐ Other: _____

**Forward completed original to: Release of Information Department at medicalrecordsroi@advocatehealth.org**

Atrium Health

Place Patient Label Here