Revocation of Authorization to Release Protected Health Information

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ROCKWOOD

Section 1 Patient Information:

Patient Name: _____
Last Name First Name M.I.

Date of Birth: _____/_____/_____ Phone Number: (_____) _____-_____
Month Day Year

Address: _____
Street City State Zip Code

Section 2 Revocation of Authorization:

I, _____, wish to revoke my Authorization for the Release of Protected Health Information (PHI) to:

_____.
(Person or places records should NOT be sent.)

I understand that this signed Revocation applies to future requests for PHI.

I understand this Revocation does not apply to PHI previously released for payment, treatment and healthcare operations or in accordance with a valid Authorization to Release previously received and processed prior to the receipt of this document.

I further understand that I am financially responsible for the payment of all services provided if and after I revoke my authorization to release information for billing purposes.

Signature of patient/legal representative: _____ Date: _____/_____/_____

Printed name of patient or legal representative: _____

Relationship to patient, if other than patient_____

Section 3 Receipt of Form

Received by: _____ Date: _____/_____/_____
Rockwood representative

Clinical Unit/Location: _____

For Health Information Management Use Only: **RWC MR#:** _____

Date Received: _____/_____/_____ _____
Initials

Documented in Centricity: _____/_____/_____ _____
Initials

Documented in Athena: _____/_____/_____ _____
Initials

Original sent to Scanning: _____/_____/_____ _____
Initials

This document will remain in effect until revoked in writing.