South Peninsula Hospital
4300 Bartlett Street
Homer, Alaska 99603

Revocation of Authorization for Disclosure of Health Information

1. I hereby revoke authorization to South Peninsula Hospital to disclose information from the health records of:

Patient Name:_____ MR# _____

Date of Birth:_____ Telephone:_____

Address: _____

This revocation of authorization covers the period(s) of healthcare:

From (date)_____ To (date)_____

From (date)_____ To (date)_____

From (date)_____ To (date)_____

From (date)_____ To (date)_____

2. I understand that disclosures made in good faith my have already occurred in reliance upon my previously issued authorization and that this revocation cannot apply retroactively to such disclosures. I also understand that the disclosure of health information may be required by law in some instances.

3. South Peninsula Hospital, its employees, officers, and physicians are hereby released from any legal responsibility or liability for disclosure of the information authorized previously.

_____ _____
Signature of Patient or Legal Representative Date

_____ _____
Signature of Witness Date

_____ _____
Signature of SPH employee assisting patient Date