
Revocation of Authorization for Disclosure of Health Information

Patient Name: _____ MRN: _____

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) _____

1. I hereby revoke authorization to South Peninsula Hospital to disclose information from the health records of the above named patient.
2. I understand that disclosures made in good faith may 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.

Patient/Representative Signature: _____ Date: _____ Time: _____

Relation to Patient: _____

Witness 1 Signature: _____ Date: _____ Time: _____

Witness 2 Signature: _____ Date: _____ Time: _____

