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Revocation of Authorization to Release Patient's Personal Health Information

This form is to be completed when a patient or Personal Representative requests to revoke or cancel an existing authorization permitting Bucks County Anxiety Center to release protected Health Information (PHI) to another person or organization.

This form is to be completed only by the patient or Personal Representative.

This revocation request only applies to the individual(s) or organization(s) listed.

(INITIAL ON THE CORRECT LINE)

a. I revoke ALL previous authorizations that I have signed: _____

b. I revoke the authorization I signed on the following date: _____ (Date and Initial)

releasing information to:

_____

I understand that my written revocation will be effective upon Bucks County Anxiety Center receiving this form. However, this revocation will not be effective for information already released to the extent that Bucks County Anxiety Center acted in compliance with privacy law when the authorization to release information was in place before I signed this revocation.

I understand that revocation will not apply to information that has already been released nor will it apply to my insurance company when the law provides the insurer with the right to contest a claim under my policy or the policy itself.

Not withstanding this revocation, Bucks County Anxiety Center shall continue to disclose PHI (personal health information) to third parties as required by law (e.g., child abuse, elder abuse, danger to self or others), which may include a disclosure(s) to the individual(s) or entity named in this revocation.

Name of Patient/Authorized Individual: _____

Signature of Patient/Authorized Individual: _____

Date: _____

Patient/Authorized Individual's Address:

_____

_____

Patient/Authorized Individual's Telephone Number:

_____