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EINSTEIN HEALTHCARE NETWORK

REVOCATION OF AUTHORIZATION TO USE AND DISCLOSE PROTECTED HEALTH INFORMATION

Patient Label (Name and Medical Record #)

Patient's Name: _____ **Date of Birth:** _____

Address: _____

_____

Home Phone: _____ **Work Phone:** _____

I hereby revoke the authorization generated by me.

I understand that this revocation will not be valid where AEHN has already acted in reliance upon my authorization:

This revocation applies to healthcare encounters of:

Specify Dates: _____ _____

_____ _____

Patient's Signature: _____ **Date:** _____

Guardian/Legal Representative: _____

Relation to Patient: _____ **Date:** _____

Instructions to Patient (or Personal Representative):

Mail or fax this form to the AEHN site of your original request/authorization to release your protected health information.

A copy of this Written Notice of Revocation shall be placed in the patient's Medical Record.

Date Received by AEHN: _____