The Eye Associates

Revocation of Authorization to Release Protected Health Information

Patient Information

Patient Name: _____Date of Birth: _____
Phone Number: _____

Revocation Statement

I hereby revoke my prior authorization(s) to release my Protected Health Information (PHI) to the individual(s) listed below:

Authorized Person(s) to Revoke

1. Name: _____
Relationship to Patient: _____
Phone Number: _____

2. Name: _____
Relationship to Patient: _____
Phone Number: _____

3. Name: _____
Relationship to Patient: _____
Phone Number: _____

☐ I am revoking authorization for all individuals previously designated to receive my PHI.

Terms of Revocation

- I understand that this revocation applies only to future disclosures of my PHI and does not affect any information already released prior to this revocation.
- I understand that this revocation does not affect disclosures made directly to me or as required by law.

Patient Signature

Patient Signature: _____Date: _____
If signed by legal representative, print name and relationship to patient:
Name: _____Relationship: _____

Practice Use Only

Received By: _____Date Received: _____
Processed By: _____Date Processed: _____