Request for Revocation of Authorization for Release of Patient-Identifiable Health Information

Date: _____

Patient Name: _____ **DOB**: _____

Identification of the Authorization to be Revoked: _____

I would like to revoke an authorization for use or disclosure of my protected health information.

I understand that I cannot revoke an authorization that has already been acted upon by Prairie Clinic SC or if the authorization was obtained as a condition of obtaining insurance coverage, another law provides the insurer the right to contest a claim under the policy.

_____
Signature of patient or other legally authorized person

_____
Date

_____
If signed by other legally authorized person, relationship to patient