Revocation of Authorization to Share Data – National

To whom it may concern at _____ *(Facility/Provider Name)*:

Effective upon receipt, I hereby immediately and permanently revoke all previous consent(s) and any authorization(s) for the use and/or disclosure of my protected health information, as allowed under federal law (and, if applicable, under state law) and as indicated below.

I understand that the revocation of my consent and any authorization, as permitted in 45 CFR 164.508, must be adhered to and is effective immediately, but does ***not*** impact protected health information that was shared prior to receipt of this revocation.

_____ I revoke all past and present consent(s) and authorization(s).

I also choose to:

_____ Allow data-sharing only with my health insurance company

_____

only for the purpose of paying my medical bills.

Please send a letter to the address listed below to confirm the date this revocation was received.

_____ _____

(Patient Name) _____

_____ _____

(Patient Date of Birth) *(Patient Address)*

_____ _____/_____/_____

(Patient Signature) *(Date)*

_____ This revocation is being signed by the personal representative listed below, on behalf of the individual.

Name of Personal Representative: _____

Relationship to Individual: _____