Revocation of Consent to Share Data – Minnesota

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.

Revocation of my consent (per MN Statute 144.293) and any authorization (per 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:

_____ Revoke consent for use of a health information exchange (HIE) record locator or patient information service. (MN Statute 144.293, Subd. 8)

_____ 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: _____