REVOCATION OF HIPAA AUTHORIZATION FOR USE, DISCLOSURE, AND ACCESS TO PHI

Patient Information
Patient Name: _____ Date of Birth: _____
Other names under which patient has been treated: _____

It is my present intent to revoke the HIPAA authorization form(s) indicated below that may currently be on file with St. Luke's Health System, Ltd. I understand this revocation does not apply to any uses or disclosures made by St. Luke's before receipt of this completed revocation form or for uses or disclosures that are allowed or required by law. I wish to revoke the following HIPAA Authorization(s): *check all that apply*

❑ **Authorization to Access, Use, and Disclose PHI**

Name of individuals/organizations/specific authorization to revoke: _____

_____

_____

❑ **Authorization to Disclose PHI for Psychotherapy Notes**

Name of individuals/organizations/specific authorization to revoke: _____

_____

_____

❑ **Authorization for Adult Proxy Access to PHI**

Name of individual(s) to revoke: _____

_____

_____

❑ **All the above HIPAA Authorizations on file with St. Luke's Health System, Ltd.**

To complete my revocation, I understand that this form must be completed in its entirety, signed, and returned to the St. Luke's HIM Department at: 190 E Bannock Street Boise, ID 83712 or fax 208-381-2438.

_____ _____ _____

Signature Date Time

_____

Relationship to the Patient (if applicable)

PATIENT LABEL or

PATIENT NAME: _____

DOB: _____ **Room #:** _____

MRN: _____ **CSN:** _____

Admit Date: _____ **Discharge Date:** _____