

Patient Name: _____

Date of Birth: _____

Medical Record Number: _____

(Please Print)

GUNDERSEN HEALTH SYSTEM®

REVOCATION OF AUTHORIZATION TO USE OR DISCLOSE PROTECTED HEALTH INFORMATION

Revocation of Authorization to Use or Disclose Protected Health Information to:

Date authorization signed by patient: _____

I understand that this request does not apply to any uses or discloses:

- Made prior to Gundersen Health System receiving this revocation; or
- Allowed or required by law.

Signature of Patient Date

(If signed by authorized person, state relationship and authority to do so.)

FOR INTERNAL USE ONLY

Date revocation form was received by Gundersen Health System: _____ (MM/DD/YYYY)

REVOCATION OF AUTHORIZATION TO USE OR DISCLOSE PROTECTED HEALTH INFORMATION

Gundersen Lutheran Medical Center, Inc. | Gundersen Clinic, Ltd. | Gundersen Boscobel Area Hospitals & Clinics | Gundersen St. Joseph's Hospital & Clinics | Gundersen Tri-County Hospital & Clinics | Gundersen Palmer Lutheran Hospital & Clinics | Gundersen Moundview Hospital & Clinics | Gundersen St. Elizabeth's Hospital & Clinics