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/YYY)