Revocation of Authorization for Release of Protected Health Information

By signing this form, you can revoke (end/terminate) a previously signed Authorization for Release of Protected Health Information (PHI), or other Authorization form. Once signed, this form will be filed with your medical records.

Patient Name: ____

Last Name First Name Middle Initial

Phone: (   ) ________________ Date of Birth: ______________ MRN: __________________ (for office staff)

By signing below, I revoke the written authorization form previously given to MindPath Care Centers for the following person or facility:

____

Name of Person or Facility for which you DO NOT wish for us to share information.

I understand that this revocation will not affect any of the actions taken before the receipt of the written revocation. A patient or the patient's legally authorized representative may not revoke a disclosure that is required for the purposes of making payment to the practice for health care services provided to the patient.

____ ________________________

Patient Signature Date