REVOCATION OF AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION (PHI)

I, _____, hereby revoke the authorization to release information I provided to UTMB that allowed UTMB to use and disclose my PHI as I outlined on the authorization form, which I signed on (date)_____ for release of my PHI to_____(facility/person). I understand that this revocation does not apply to any action UTMB has taken in reliance on the authorization I signed earlier. This revocation does not revoke any and all previous authorizations to release information that I have provided to UTMB.

_____ _____
Patient Name or Personal Representative Date

Special Provisions

In this section, the individual should outline any special provisions regarding the revocation of the authorization.

_____

_____

_____

_____

_____ _____
Patient Name or Personal Representative Date

NOTICE

Route this form to Health Information Management after the individual has completed filling in the information:

Health Information Management (HIM)
301 University Boulevard
Galveston, Texas 77555-0782

UTMB STRICTLY PROHIBITS CHANGES TO THIS FORM.

IF PATIENT ID CARD IS UNAVAILABLE, WRITE DATE, PT NAME AND UH# IN SPACE BELOW

REVOCATION OF AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION (PHI)

Medical Record Form 7075-3/03
The University of Texas Medical Branch Hospitals
Galveston, Texas

Original-Medical Record