Patient Revocation of Authorization for Release of PHI

Federal Law states that your healthcare provider cannot share or request your protected health information (PHI) without your authorization *except* for treatment, payment and healthcare operations. You can identify in writing a person or entity that you would like us to share your information with and we will accommodate all reasonable requests.

If you have Authorized us to share your information with a person or entity and would like to revoke that Authorization the below form must be completed.

Please complete the below information (any section that is left blank may delay our response to your request)

Patient Name (Print): _____ DOB: _____

Phone (home or mobile): _____ Date of Request: _____

I hereby authorize (select one) □ AKDHC □ PKDHC to ***revoke*** a previous authorization to disclose my protected health information to (print name): _____

Authorized Person's Relationship to me:

□ Family Member □ Friend □ Other (identify relationship) _____

□ The identified person is also no longer authorized to participate in any appointment and billing activities related to my care.

_____ _____

Patient or Legal Representative **Printed** Name Patient or Legal Representative **Signature**

_____

Date

All requests for the revocation of an Authorization should be documented in writing and directed to the AKDHC/PKDHC Privacy Officer. Completed request forms should be mailed to the Privacy Office using the contact information below or handed to the office staff who will direct the request to the Privacy Office for you.

AKDHC Administration Attn: Privacy Officer
3333 East Camelback RD Suite 180
Phoenix, AZ 85018

Phone: 602-997-0484

OFFICE USE ONLY:			
Request Received By:		Date:	