Patient Name:____________________________

Medical Record Number:___________________

Contact Serial Number:___________________

La Crosse, WI 54601

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)