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)