

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/YYYY)

#### REVOCATION OF AUTHORIZATION TO USE OR DISCLOSE PROTECTED HEALTH INFORMATION

Gundersen Lutheran Medical Center, Inc. | Gundersen Clinic, Ltd. | Gundersen Boscobel Area Hospitals & Clinics | Gundersen St. Joseph's Hospital & Clinics | Gundersen Tri-County Hospital & Clinics | Gundersen Palmer Lutheran Hospital & Clinics | Gundersen Moundview Hospital & Clinics | Gundersen St. Elizabeth's Hospital & Clinics