Health Information Management

REVOCATION OF PROTECTED HEALTH INFORMATION FORMS

Patient Name_____Prior Name:_____ _____
Patient Telephone No.

Patient Address:_____ _____
Street City State Zip Date of Birth

I, _____, would like to revoke the:
(Printed Name)

☐ **Authorization for Release of Protected Health Information Form**

☐ **Release of Verbal Information Form**

in the above patient's chart dated _____. This revocation shall go
(Date Original Form was Signed)

into effect as of _____.
(Today's Date)

_____ _____ _____ _____
Signature of Patient or Legal Guardian | Relationship | Date | Time

_____ _____ _____ _____
Signature of Trinity Staff Person | Department | Date | Time

****Send form to the ROI Supervisor or HIM Operations Manager once signed****

LEG4

PATIENT LABEL