REVOCATION OF AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION

I, _____, hereby revoke the authorization to release information I provided to the Muslim Community Center Medical Center that allowed the Muslim Community Center Medical Center to use and disclose my protected health information as I outlined on the authorization form, which I signed on (date) _____ for release of my protected health information to (facility/person) _____. I understand that this revocation does not apply to any action the Muslim Community Center Medical Center has taken in reliance on the authorization I signed earlier. This revocation does not revoke any and all previous authorization to release information that I have provided to the Muslim Community Center Medical Center.

_____ _____

Patient Printed Name | Medical Record/Account Number

_____ _____

Patient/Patient Representative Signature | Date

_____ _____

If Patient Representative, Relationship to Patient | Printed Name

SPECIAL PROVISIONS

In this section, any special provisions regarding the revocation of the authorization should be detailed. If there are none, indicate "none".

_____

_____

_____

_____ _____

Patient/Patient Representative Signature | Date

RESET PRINT

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Fax: (301)384-0166