



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