REVOCATION OF RELEASE HEALTH INFORMATION AUTHORIZATION FORM

Patient Information:

Patient's Name: ____
Last First Middle Date of Birth

Home Address: ____
Street City State Zip Code

Home Phone: (________) ____________________ Cell Phone: (________) ____________________________________

I ____, give permission for the following CHS Facility/Practice:
(Patient/Legal Guardian)

____
(CHS Facility/Practice Name)

To Revoke the Release of Health Information Authorization completed to disclose health information to:

Person/Organization/Agency:____

Address:____

Date Authorization was completed: ____

Statement of Revocation:
I give permission to the following authorizations previously given to Carolinas Healthcare System to disclose my Protected Health Information as specified in said requests, that has not already expired, been previously revoked, or to the extent that action has been taken in reliance on it.

Please note: To revoke a Payment and Reimbursement Authorization, please contact the Business Office at 704-512-7000. This revocation cannot be done on this form as this form only revokes authorization for medical records not billing records.

Disclaimer:
I understand that this revocation will not affect any of the action taken before the receipt of this written revocation. A patient or the patient's legally authorized representative may not revoke a disclosure that is required for the purposes of making payment to Carolinas Healthcare System for care provided to the patient if the bill has not been paid in full, or for any disclosure required by law.

____
Signature of patient or patient's representative

____:______________________
Date Time of Revocation AM/PM

FOR CHS STAFF USE ONLY:

- ☐ Authorization stamped "Revoked"
- ☐ Scan with revoked authorization to Canopy 910, 906, 905

Original: File or Scan in medical record.

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Carolinas HealthCare System