Southcentral Foundation

Release of Protected Health Information Revocation Form

I hereby request the authorization to release protected health information dated _____ authorizing the release of my protected health information (PHI) to: _____ be withdrawn. This revocation will not affect any actions taken before the receipt of this written revocation.

Customer-owner name	MRN# (if known)
Signature of patient or patient's representative	Date
Name of patient representative	Relationship to patient

FOR OFFICE USE ONLY (this section is to be completed by SCF staff only):

Date revocation request was received:	Date revocation request was processed:

Was the information disclosed prior to receiving this request for revocation:

If yes, describe what information had already been disclosed:

If this is a verbal revocation request and is limited to the release of Alcohol or Drug Treatment information, please complete this section.
Date and Time of verbal request: _____

Request made by: _____

If other than customer-owner, describe relationship or authority to request for revocation:
_____

Print Name / Title of SCF Employee processing request	Signature of SCF Employee processing request	Date