TULANE UNIVERSITY MEDICAL GROUP

REVOKE AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION (PHI)

Patient's Name:	Birth Date:	SS#:
Address:		Telephone #:

I hereby REVOKE authorization from

____

to release the health information of

____

to

____

that was granted for the purpose of

____

Type of access that was granted:

- ❑ Entire Medical Record
- ❑ Itemized bill
- ❑ Other____

____

(Date) (Signature of Patient/Guardian/Patient Representative) (Relationship to Patient)

____

(Printed name)

*Revocation of authorization for release of information except to the extent the action has been taken in reliance upon it.