



Revocation of Authorization for Release of Protected Health Information

I hereby revoke my authorization dated _____ and previously given to **University Health System (UHS)** to disclose my Protected Health information. I understand this revocation will not affect any of the actions taken before the receipt of the 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 the hospital for health care provided to the patient.

Patient name

Date of birth

Social Security Number

MRN

Date of service: _____

Signature of patient or patient's representative

Date

Name of patient representative

Relationship to patient

University Health System, 4502 Medical Drive, Medical Records Department, MS 26-2,
San Antonio, TX 78229-4493

Phone number: (210) 358-3532 Fax number: (210) 358-5936