4502 Medical Drive
Medical Records Department, MS# 26-2
Phone (210) 358-3532 San Antonio, Texas 78229-4493 Fax (210) 358-5936

Revocation of Authorization for Release of Protected Health Information

INSTRUCTIONS TO PATIENTS: By signing this form, you can revoke (end/terminate) a previously signed Authorization for Release of Protected Health Information (PHI), or other Authorization form. Submit this signed form to Medical Records, Release of Information Department at the above address. This form will be filed with your medical records.

Patient's Name: ____
Last First Middle

Address: ____
Street City State Zip Code

Phone: (____)________________ **Date of Birth:** ______________ **MRN:** ________________________

By signing below, I **revoke** the written Authorization form previously given to **University Health System (UHS)** signed by me on ________________.
Month/Day/Year

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 services provided to the patient.

____ ______________
Patient Signature Date

____ __________________________ ______________
Signature of Other Person Legally Authorized To Revoke Authorization on Behalf of Patient | Relationship to Patient | Date

FOR UNIVERSITY HEALTH SYSTEM USE ONLY **DATE RECEIVED**____________________

DATE ENTERED INTO 3M CHART RELEASE: ________________________

DATE SCANNED IN PATIENT'S MEDICAL RECORDS:__________________________

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RELEASE OF INFORMATION MANAGER/STAFF PROCESSING REQUEST