

HUNTINGTON MEDICAL FOUNDATION

REVOCATION OF AUTHORIZATION TO RELEASE MEDICAL RECORDS

(Name) _____

who resides at _____

hereby revokes authorization to the physician, hospital, clinic, lab, radiology center or other healthcare provider listed below:

Name _____

Address _____

City/St/ZIP _____

to disclose information from the medical records of:

Name _____

Address _____

City/St/ZIP _____

My revocation extends to the data or documents I have initialed below:

_____ Records of visits (all visits)

_____ Record of visit for a specific date or dates, including or limited to:

_____ Copies of records or reports provided to the above named (i.e. hospital, lab, etc.

_____ Statements of charges or payments

_____ Mental health, alcohol and/or drug abuse treatment:

_____ HIV information

_____ Hepatitis information

_____ Other (specify) _____

This revocation is given freely and with the understanding that:

1. Disclosures made in good faith may have already occurred based on my previously issued authorization and that this revocation cannot apply retroactively to such disclosures. I also understand that the disclosure of health information may be required by law in some instances, such as for the reporting of communicable diseases.
2. The facility, its employees, officers, and physicians are hereby released from any legal responsibility or liability for disclosure of the information I authorized previously.

Patient's name (print) _____

Patient's signature _____

Patient's Social Security number (for identification purposes only):

Today's date ____/____/____

Revocation date ____/____/____

(if other than 60 days from date above)

Witness's name (print) _____

Witness's signature _____

You may fax this form to the HMF Medical Records office at:

626/397-8350 or 626/397-8337.