Patient (First, Middle, Last)	
Date of Birth	MR#
Address	
City/State	Phone #

Revocation of Authorization To Release Health Information

Keystone Health
Attn: HIM Department
111 Chambers Hill Drive, Suite 200
Chambersburg, PA 17201
Phone (717) 709-7960 Fax (717) 217-1937
Email: khc-him@keystonehealth.org

This form is to be completed when a patient requests to revoke or cancel an existing authorization permitting Keystone Health to release protected Health Information (PHI) to another person or organization. This form is to be completed only by the patient or Personal Representative. This revocation request only applies to the individual(s) or organization(s) listed.

(INITIAL BELOW)

a. _____ I revoke ALL previous authorizations that I have signed.

b. _____ I revoke the authorization I signed on the following date:_____
releasing information to:_____

c. _____ I request the authorization I signed on the following date:_____
releasing information to:_____
be modified to revoke authorization to release the following specific protected health information (list information, you DO NOT want released):_____
_____

I understand that my written revocation will be effective upon receipt, but will not be effective to the extent that the requester or others have acted in reliance upon the authorization that I provided prior to this revocation.

I understand that revocation will not apply to information that has already been released nor will it apply to my insurance company when the law provides the insurer with the right to contest a claim under my policy or the policy itself.

Not with standing this revocation, Keystone Health shall continue to disclose PHI to third parties as required by law, which may include a disclosure(s) to the individual(s) or entity named in this revocation.

_____ _____
Signature of Patient/Authorized Personal Representative Date

_____
Authorized Personal Representative's /Relationship to Patient