

Revocation of Authorization to Share Data – National

To whom it may concern at US Metro Hospital (Facility/Provider Name):

Effective upon receipt, I hereby immediately and permanently revoke all previous consent(s) and any authorization(s) for the use and/or disclosure of my protected health information, as allowed under federal law (and, if applicable, under state law) and as indicated below.

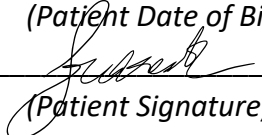
I understand that the revocation of my consent and any authorization, as permitted in 45 CFR 164.508, must be adhered to and is effective immediately, but does **not** impact protected health information that was shared prior to receipt of this revocation.

JR I revoke all past and present consent(s) and authorization(s).

I also choose to:

JR Allow data-sharing only with my health insurance company
Any Insurance United
only for the purpose of paying my medical bills.

Please send a letter to the address listed below to confirm the date this revocation was received.

<u>Jane Roe</u>	<u>123 Main St.</u>
(Patient Name)	<u>Anytown, USA 12345</u>
<u>11-04-1953</u>	
(Patient Date of Birth)	(Patient Address)
<u></u>	<u>07 / 02 / 2020</u>
(Patient Signature)	(Date)

_____ This revocation is being signed by the personal representative listed below, on behalf of the individual.

Name of Personal Representative: _____

Relationship to Individual: _____