Revocation of Authorization for Release
of Protected Health Information

I hereby revoke my authorization dated ______________________ and previously given to Arise Austin Medical Center (AAMC) 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.

______________________________	______________________
Printed Patient Name	Date of Birth
______________________________	______________________
Social Security Number	MRN

Date(s) of Service____

______________________________	______________________
Signature of patient or patient's representative	Date
______________________________	______________________
Printed name of patient representative	Relationship to patient

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