Pharmacy Form
Revocation of Authorization to Release Health Information

What is the Purpose of this Revocation?
This form is used by a Patient or Patient's personal representative to revoke a prior authorization to allow Wal-Mart, SAM'S Club, and Neighborhood Market Pharmacies (collectively "Pharmacy") to release health information to an individual or organization not otherwise authorized by law to receive this information, as required by the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") and other state and federal privacy laws.

Section 1: Patient Information

Patient Name:			Date of Birth:
Address:			
City:	State:	Zip:	Phone:

Section 2: Revocation Information

I, _____, hereby revoke the Authorization to Release Health Information which I signed on (date) _____, that allowed the Pharmacy to release my Protected Health Information to the recipient and for the purpose listed below. I understand that this revocation does not apply to any action the Pharmacy has already taken in reliance on the Authorization I signed earlier. This revocation does not revoke any other Authorizations to release information that I have previously provided to the Pharmacy.

Section 3: Recipient

Recipient Name:			Phone:
Name of Organization:			
Street Address:			
City:	State:	Zip:	Phone:
The purpose of this Authorization is:	☐ At the request of the Patient / Patient's personal representative ☐ Other (state reason): _____		

Section 4: Signature

_____ _____
Signature of Patient or Personal Representative Today's Date

If you have signed this form as a legally authorized representative of the Patient, please print your name and relationship to the Patient below.

_____ _____
Name of Personal Representative (please print) Relationship to Patient (parent, legal guardian, etc.)

☐ Please check (✓) this box if you would like to receive a copy of this form after you have signed it.