Dayspring Family Medicine Associates

REVOCATION OF AUTHORIZATION FOR DISCLOSURE OF HEALTH INFORMATION

1. I hereby revoke my previous authorization(s) to Dayspring Family Medicine Associates to disclose information from the health records of:

   Patient name _____ Date of birth _____

   Address _____ Telephone _____

   Patient number _____

   Prior Authorization(s):

   Dated: _____ Recipient: _____

   Dated: _____ Recipient: _____

2. I request to ***revoke*** my authorization to release the following information:

   ☐ **ALL** protected health information

   ☐ Acquired Immunodeficiency Syndrome (AIDS)

   ☐ HIV Test results

   ☐ Sexually Transmitted Diseases

   ☐ Treatment for alcohol and/or drug abuse

   ☐ Psychotherapy Notes (from the records of my treatment by a psychiatrist, licensed psychologist or psychiatric clinical nurse specialist)

   ☐ Other (please specify) _____

3. I understand that disclosures made in good faith may have already occurred in reliance upon 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.

4. Dayspring Family Medicine Associates, its employees, officers, and physicians are hereby released from any legal responsibility or liability for disclosure of the information I authorized previously.

_____ _____

Signature of Patient or Authorized Party Date

_____

Printed Name

_____

Relationship to Patient