THE BEHAVIORAL HEALTH WELLNESS CLINIC
Alaska Native Tribal Health Consortium
3801 University Lake Drive, Suite 205 Anchorage, AK 99508
Phone: (907) 729-2492 or (833) 642-2492 / Fax: (907) 729-3950

HIPAA REVOCATION OF AUTHORIZATION FORM

Purpose: This form is used to revoke or to confirm revocation of a previously authorized disclosure. You may make this revocation at any time by giving written notice to a Privacy Contact listed on our Notice of Privacy Practices. You may only revoke an authorization you made for yourself or your minor child. This revocation of authorization will not affect any action we took in reliance on the initial authorization prior to receiving this notice.

SECTION A: INDIVIDUAL REVOKING THE AUTHORIZATION

This section is used to identify the individual who is the subject of the information, usually yourself. (If you are a parent, you may also revoke any authorization you made for the release of health information for your minor child.)

Name: _____ Social Security Number (last four #):_____

Address: _____ Date of Birth: _____

Telephone Number: _____ E-Mail Address: _____

SECTION B: INDIVIDUAL'S STATEMENT OF REVOCATION

I revoke my authorization for the use and/or disclosure of the protected health information described in Section C below. If available, a copy of the original authorization should be attached.

I understand that this revocation will not affect any action Radiology Ltd., PLC, RLC, LLC, or others took in reliance on my previous authorization and before receipt of this written revocation.

Copy of authorization attached:

☐ Yes

☐ No (complete section C.)

SECTION C: DESCRIPTION OF AUTHORIZATION REVOKED (COMPLETE IF AUTHORIZATION NOT ATTACHED)

Date of authorization (if known): _____

This Revocation of Authorization applies to the following protected health information:

Specific description of information to be revoked. (This would be the information you authorized to be released. Examples: "All information necessary to coordinate treatment and payment for my health care needs," or "All claims and benefit information for treatment at clinic in February YYYY.")

_____
_____

Person/Organizations authorized to provide the information. This could be a provider, clinic, hospital and/or health insurance company. Examples: “ABC Health Plan,”

_____
_____

Person/Organizations authorized to receive the information. Please provide the full name (or other means to identify) of the person or business you want to revoke authorization to receive the information you authorized for release. Examples: “Jane Doe, spouse,” or “ABC Health insurance”.

_____
_____

SECTION D: INDIVIDUAL’S SIGNATURE

To be valid, this Revocation of Authorization must be signed and dated by the person listed in Section A. Parents may sign this Revocation of Authorization if it relates to the release of health information on their minor child(ren). If you are signing this form in the capacity of the patient’s personal representative, such as a parent, guardian or power of attorney, you must also include your name and relationship to the person listed in Section A.

I have had full opportunity to read and consider the contents of this Revocation of Authorization.

_____ _____

Signature: Date:

If this Revocation of Authorization is being signed by a personal representative on behalf of the individual, please complete the following:

Personal Representative’s Name: _____

Relationship to Individual: _____

AFTER YOU HAVE SIGNED THE REVOCATION OF AUTHORIZATION, KEEP A COPY FOR YOUR RECORDS and send to THE BEHAVIORAL HEALTH WELLNESS CLINIC Alaska Native Tribal Health Consortium 3801 University Lake Drive, Suite 205 Anchorage, AK 99508 Phone: (907) 729-2492 or (833) 642-2492 / Fax: (907) 729-3950. If you have questions about completing this form, contact us at the numbers above.