SALUS

AUTHORIZATION REVOCATION

Purpose: This form is used to revoke or to confirm revocation of an authorization previously given.

SECTION A: Individual revoking the authorization.

Name: _____

Address: _____

Telephone: _____ E-mail: _____

Medical Record Number: _____

SECTION B: Individual's statement of revocation.

I revoke the authorization attached to this form or granted on (date) _____.

I understand that this revocation will *not* affect any action SALUS took in reliance of my authorization before receipt of this written revocation.

Authorization enclosed? ☐ Yes. ☐ No (complete Section C).

SECTION C: Description of authorization revoked (complete if authorization not attached

Date of authorization (if known): ____/____/____

Protected Health Information Affected: The revoked authorization applied to the following information:

_____

_____

Entities Authorized to Receive and Use: The revoked authorization allowed the information described above to be received and used by the following persons and/or organizations:

_____ _____

_____ _____

INDIVIDUAL'S SIGNATURE

Signature: _____ Date: _____

If this revocation is signed by a personal representative on behalf of the individual, complete the following and submit evidence of authority:

Personal Representative's Name: _____

Relationship to Individual: _____