westmed medical group

Health Management Information Department
2700 Westchester Avenue
Purchase, NY 10577

REVOCATION OF AUTHORIZATION

To Verbally Communicate Protected Health Information

Patient Name:	Phone Number:
Patient Address: Street, City, State, Zip	
Medical Record #:	Date of Birth: MM DD YY

I hereby revoke the "Authorization to Communicate Protected Health Information Form" that I submitted previously on _____(include date).

This revocation shall be effective on _____(include date).

I no longer wish to authorize WESTMED Medical Group to communicate Protected Health Information ("PHI") about me to _____(insert name or names).

TO BE READ AND SIGNED BY PATIENT:

I understand the following:

a) I may not be able to revoke my prior authorization if Westmed has already taken action utilizing that authorization or if that authorization was obtained as a condition of obtaining insurance coverage.
b) I am signing this revocation freely and under no pressure from any individual to do so.
c) I acknowledge that I have had an opportunity to review this revocation and understand the intent to use.
d) I will receive a copy of this completed and signed revocation form.
e) I can submit a new authorization to communicate health information at any time.

Patient Signature		Date
Signature of Patient's Representative	Relationship	Date

OFFICE USE ONLY:

□ I.D. Verified: Type _____ Initials _____