



REVOCAION OF AUTHORIZATION TO USE AND/OR DISCLOSE HEALTH INFORMATION

The Health Insurance and Portability Act of 1996 (HIPAA) provides an individual the right to revoke a previous authorization to disclose information at any time. You are required to provide a request in writing for revocation and/or cancellation of the original verbal or written record release.

I understand that by signing below, this revokes the previous authorization to disclose my protected health information (listed below), and that Astria Health and its clinics will not be held responsible for any release of information accomplished prior to the receipt of this written notice of revocation.

I understand that no revocation of this consent shall be effective to prevent disclosure of records and/or communications until it is received by the person/s otherwise authorized to disclose records and communications, i.e. Health Information Management Department.

I further understand that the revocation will only apply to further disclosures or actions regarding my personal health information and cannot cancel actions or disclosures made while the disclosure was previously in effect and valid.

If you have any questions concerning the revocation process, please contact the Health Information Management Department at 509-837-1636.

Patient Name: _____ DOB: _____

I am Revoking Verbal Authorization that was given to:
Name of Individual(s): _____ Relationship: _____ Phone: _____

I am Revoking Authorization for Written Information or Copies of Medical Records given to:
Name of Individual(s): _____ Relationship: _____ Phone: _____

Signature:

Patient/Representative: _____ Date: _____

Legal Authority: Self Parent Legal Guardian Medical Power of Attorney

Other: (Please list) _____

****Please attach Legal Documentation if you are the Legal Guardian or holder of Power of Attorney**

This Revocation of Authorization can be sent to us by Mail, Fax or Email:

**Astria Health – Health Information Dept. 1016 Tacoma Ave, Sunnyside, WA 98944
Phone: 509-837-1636, Option 1 for Release of Information, Fax: 509-837-1637, Email: ROI@Astria.Health
Monday – Friday, 8:00am – 4:30pm, Closed all major Holidays**