MRN________________________

REVOCATION OF INFORMED CONSENT FOR RELEASE OF PATIENT HEALTH INFORMATION FORM

_______________________________________ _____________ ______________ __________________________

Patient Name *(Please Print)* Last 4 of SS# Date of Birth Phone Number

I understand that prior to BayCare Clinic, LLP ("BayCare") receiving this form, information may be released in accordance with the original authorization. I understand that only the forms identified below will be revoked.

Revocation of Authorization

Please mark the authorizations you wish to revoke:

☐ **Release of Information and Authorization to Disclose – Written Records**

I hereby revoke the authorization I previously provided on (*date*) ____/______/______ that allowed BayCare Clinic to disclose to ____*(facility/person).*

SIGNATURE OF PATIENT/LEGAL REPRESENTATIVE: ______________________________DATE:

If signed by person other than the patient, state the relationship and authority to do so.

Patient is: ☐ Minor ☐ Legally Incompetent or Incapacitated ☐ Deceased

Legal Authority:

☐ Legal Guardian ☐ Parent ☐ Executor of Deceased/Next of Kin ☐ Activated Power of Attorney for Healthcare

☐ Other Legal Representative of patient *(specify)*:____

If the original Authorization you are requesting for revocation has not yet been received, this revocation form will be sent back to you.

Note: It is the patient's responsibility to inform the previously authorized requester of information that the Authorization has been revoked.

Please mail to: BayCare Clinic
Attn: Release of Information Dept
P.O. Box 28900
Green Bay, WI 54324-0900

Or FAX to: (920) 544-5586
Questions: Call the Release of Information Dept at: (844) 544-5414

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(For Internal Use Only)

*Received By:*______________________________ *Date:*__________*Sent to ROI:(Date)*___________________________
(If received by a Clinic Site)

*Revoked By:*____________________________________*Date:*____________________*Release Restriction Applied* ☐