MIND SPRINGS *health* WEST SPRINGS *hospital*
Prevention. Care. Recovery. Psychiatric Care & Recovery

HIPAA REVOCATION OF AUTHORIZATION FORM

Today's Date: _____

Client Name: _____ Date of Birth: _____

I revoke my authorization for use and disclosure of protected health information for:

_____

I understand that this revocation will not affect any action Mind Springs Health & West Springs Hospital or others took in reliance on my previous authorization and before receipt of this written revocation.

Signature: _____

Personal Representative's Name: _____

Personal Representative's Relationship: _____

Please indicate any other individuals or entities that we should notify of this revocation:

_____

_____

_____

_____