



4502 Medical Drive  
 Medical Records Department, MS# 26-2  
 San Antonio, Texas 78229-4493  
 Phone (210) 358-3532 Fax (210) 358-5936

## Revocation of Authorization for Release of Protected Health Information

**INSTRUCTIONS TO PATIENTS:** By signing this form, you can revoke (end/terminate) a previously signed Authorization for Release of Protected Health Information (PHI), or other Authorization form. Submit this signed form to Medical Records, Release of Information Department at the above address. This form will be filed with your medical records.

**Patient's Name:** \_\_\_\_\_  
 Last First Middle

**Address:** \_\_\_\_\_  
 Street City State Zip Code

**Phone:** (\_\_\_\_) \_\_\_\_\_ **Date of Birth:** \_\_\_\_\_ **MRN:** \_\_\_\_\_

By signing below, I **revoke** the written Authorization form previously given to **University Health (UH)** signed by me on \_\_\_\_\_  
 Month/Day/Year

I understand this revocation will not affect any of the actions taken before the receipt of the written revocation. A patient or the patient's legally authorized representative may not revoke a disclosure that is required for the purposes of making payment to the hospital for health care services provided to the patient.

\_\_\_\_\_  
 Patient Signature \_\_\_\_\_  
Date

\_\_\_\_\_  
 Signature of Other Person Legally Authorized  
 To Revoke Authorization on Behalf of Patient \_\_\_\_\_  
Date

\_\_\_\_\_ Relationship to Patient

**FOR UNIVERSITY HEALTH USE ONLY** **DATE RECEIVED** \_\_\_\_\_

**DATE ENTERED INTO 3M CHART RELEASE:** \_\_\_\_\_

**DATE SCANNED IN PATIENT'S MEDICAL RECORDS:** \_\_\_\_\_

\_\_\_\_\_  
**RELEASE OF INFORMATION MANAGER/STAFF PROCESSING REQUEST**

