ROCKWOOD
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# Revocation of Authorization to Release Protected Health Information

| **Section 1** | **Patient Information** |
|---|---|

Patient Name: ______________________________________________________________________
Last Name First Name M.I.

Date of Birth: ________/_______/________
Month Day Year

Address: ____________________________________________________________________________
Street City State Zip

| **Section 2** | **Revocation of Authorization** |
|---|---|

I, ______________________________________________ wish to revoke my Authorization for the Release of

Protected Health Information (PHI) to: __________________________________________________________
(Person or place records should NOT be sent)

I understand that this signed Revocation applies to future requests for PHI.

I understand this Revocation does not apply to PHI previously released for payment, treatment and healthcare operations or in accordance with a valid Authorization to Release previously received and processed prior to the receipt of this document.

I further understand that I am financially responsible for the payment of all services provided if and after I revoke my authorization to release information for billing purposes.

Signature of patient/legal representative__________________________________________Date_____/_____/______

Printed name of patient or legal representative________________________________________

Relationship to patient, if other than patient____________________________________________

| **Section 3** | **Receipt of Form** |
|---|---|

Received by: ____________________________________ Date:______/______/_______
Rockwood representative

Clinical Unit/Location: __________________________________

**For Health Information Management Use Only:** **RWC MR#: _____________________**

Date Received: _____/______/________ ____________ Initials

Documented in Centricity: _____/______/________ ____________ Initials

Documented in GPMS: _____/______/________ ____________ Initials

Original sent to Scanning: _____/______/________ ____________ Initials

**This document will remain in effect until revoked in writing.**