PROVIDENCE
Health & Services

REVOCATION OF RESTRICTION TO USE OR DISCLOSE PROTECTED HEALTH INFORMATION

This form is for the purpose of a patient/patient representative to terminate or revoke restrictions in place for use or disclosure of protected health information.

For which state you are requesting this revocation:

☐ Alaska ☐ California ☐ Montana ☐ Oregon ☐ Washington

Patient Last Name: First Name:

Middle Initial: DOB: Phone:

Address:

I revoke the requested restriction for:

I understand this request does not apply to any use or disclosures that may occur before the provider(s) receives this revocation or as allowed and required by law.

Sign: Date:

Signature of Patient or Patient Representative

If personal representative signs this request on behalf of the patient, complete the following:

Print Name:

Description of personal representative's authority:

*Attach legal documentation if you are the legal guardian or Power of Attorney for Healthcare

For Internal Use Only

PHS terminates the agreement of your requested restriction dated:

The reason for the termination of this agreement is:

☐ The individual has agreed to or has requested the termination in writing.
☐ The individual orally agrees to the termination and the oral agreement is documented.
☐ This termination notice is only effective with respect to protected health information created or received after the date of this notice,

Date Received: Initials: MRN: