REQUEST TO REVOKE A PHI RESTRICTION

You have the right to revoke a Protected Health Information Restriction that has been agreed to by AKDHC or PKDHC. By completing this form, you are documenting that you would like to revoke a current restriction that is in place.

Please complete the below information (any section that is left blank may delay our response to your request)

PATIENT INFORMATION			
Last Name	First Name		M.I.
Address	City	State	Zip
Date of Birth	Phone		

Restricted Person/Entity (select one):

□ Person (print name and relationship): _____

□ Health Plan (print name): _____

Health Plan Restrictions: Any restriction in place for a Health Plan only relates to the specific services provided that were paid for by you in full at time of service.

I hereby revoke the above restriction.

_____ _____

Patient or Legal Representative **Printed** Name | Patient or Legal Representative **Signature**

_____

Date

If the above signature is the patient's Legal Representative complete the following:

LEGAL REPRESENTATIVE INFORMATION			
Last Name	First Name		M.I.
Address	City	State	Zip
Representative capacity (e.g. power of attorney, legal guardian, executor of estate):	Phone		

Submitting a Restriction Revocation Form:

All requests for the revocation of a PHI Restriction should be documented in writing and directed to the AKDHC/PKDHC Privacy Officer. Completed request forms should be mailed to the Privacy Office using the contact information below or handed to the office staff who will direct the request to the Privacy Office for you.

AKDHC Administration Attn: Privacy Officer
3333 East Camelback RD Suite 180
Phoenix, AZ 85018

Phone: 602-997-0484

OFFICE USE ONLY:			
Request Received By:		Date:	