REQUEST TO REVOKE A PHI AUTHORIZATION

If you have Authorized us to share your information with a person or entity and would like to revoke that Authorization the below form must be completed.

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		

I hereby authorize (select one) □ AKDHC □ PKDHC to *revoke* a previous authorization to disclose my protected health information

to (print name): ____

Authorized Person's Relationship to me:
□ Family Member □ Friend □ Other (identify relationship) _____________________________

______________________________ 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 Revocation Request Form

All requests for the revocation of an Authorization 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:	