KEWAUNEE COUNTY

WRITTEN NOTICE OF REVOCATION OF AUTHORIZATION TO USE AND DISCLOSE PROTECTED HEALTH INFORMATION

Individual's Name: _____
Last First Middle

Home Address: _____
_____

Home Telephone: _____ **Date of Birth:** _____

I hereby revoke the authorization generated by me on _____ [insert date], a copy of which is attached to this form.

I understand that this revocation will not be valid where Kewaunee County has already acted in reliance upon my authorization.

_____ _____
Signature of Patient (or Personal Representative) Date

_____
Printed Name of Personal Representative

Relationship to Patient: _____

Instructions to Patient (or Personal Representative):

Mail, fax or bring this Written Notice of Revocation to Kewaunee County's Departmental Privacy Office at _____, facsimile number: (____) ____-_____. If you have any questions regarding this form, you may contact the Department Privacy Office in person or by telephone at (____) ____-_____.

For Kewaunee County's Internal Use Only:

The date on which this Written Notice of Revocation was received by Kewaunee County is: _____. A copy of this Written Notice of Revocation shall be placed in the patient's medical record.