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

INDIVIDUAL'S INFORMATION

Individuals's Name: _____ Date of Birth: _____

Address:_____City:_____ State: _____ Zip: _____

Telephone: _____

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 Genesis Health System Affiliated Entities have already acted in reliance upon my authorization.

Signature of Patient (or Personal Representative): _____

Date:_____

Printed Name of Personal Representative: _____

Relationship to Patient: _____

Mail, fax or bring this Written Notice of Revocation to the Genesis Health System Corporate Privacy Office. If you have any questions regarding this form, you may contact the Corporate Privacy Office in person, by telephone at (563) 421-7262.

MAIL TO:
Genesis Health System
Health Information Management
My Genesis Revoke Access Request
1227 East Rusholme Street
Davenport, IA 52803

FAX TO:
(563) 421-7299

OFFICE USE ONLY
The date on which this Written Notice of Revocation was received by Genesis Health System Corporate Privacy Office is:_____. A copy of this Written Notice of Revocation shall be placed in the patient's medical record.