REVOCATION OF
AUTHORIZATION FORM

Purpose: This form is used for revoking or confirming the revocation of a previously granted authorization.

SECTION A: Person revoking the authorization.

Name: ____

Address: ____

Phone Number: ______________________ Email: _____________________________

Medical Record: _____________________ Social Security Number: _______________

SECTION B: Personal statement on the revocation.

I hereby revoke the authorization hereby attached or which was granted on (date):

I understand that this revocation will *not* have any effect whatsoever on any action taken by Salus based on my authorization before receiving this revocation in writing.

Is the authorization attached? ☐ Yes ☐ No (complete Section C).

SECTION C: Description of the authorization to be revoked. (Complete if the authorization is not attached)

Date of authorization (if known)_________/____/____

Affected information: This revocation applies to the following information:

____

____

Entities authorized to receive and use the information: The revoked authorization allowed the following persons and entities to receive and use the information:

_____________________________________ _____________________________________

_____________________________________ _____________________________________

SIGNATURE OF REQUESTER – You are entitled to receive a copy of this request after signing it.

Signature: _________________________________ Date: ____________________________

If this revocation is signed by a personal representative on behalf of the requester, please provide the following information and submit evidence of authorization to sign:

Name of Personal Representative: ____

Relationship to the Insured Person: ____