Generations Family Practice

REVOCATION OF AUTHORIZATION FOR DISCLOSURE OF HEALTH INFORMATION

1. I hereby revoke my previous authorization(s) to ***Generations Family Practice*** to disclose information from the health records of:

   Patient name ___________________________________ Date of birth _________________

   Address ____ Telephone _____________

   Patient number _______________________

   Prior Authorization(s):

   Dated: ________________________ Recipient: _______________________

   Dated: ________________________ Recipient: _______________________

2. I request to ***revoke*** my authorization to release the following information:

   ☐ **ALL** protected health information
   ☐ Acquired Immunodeficiency Syndrome (AIDS)
   ☐ HIV Test results
   ☐ Sexually Transmitted Diseases
   ☐ Treatment for alcohol and/or drug abuse
   ☐ Psychotherapy Notes (from the records of my treatment by a psychiatrist, licensed psychologist or psychiatric clinical nurse specialist)
   ☐ Other (please specify) ____

3. I understand that disclosures made in good faith may have already occurred in reliance upon my previously issued authorization and that this revocation cannot apply retroactively to such disclosures. I also understand that the disclosure of health information may be required by law in some instances, such as for the reporting of communicable diseases.

4. ***Generations Family Practice***, its employees, officers, and physicians are hereby released from any legal responsibility or liability for disclosure of the information I authorized previously.

__________________________________ _______________________
Signature of Patient or Authorized Party Date

____
Printed Name

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Relationship to Patient