UT Southwestern Medical Center

Revocation of Prior Authorization for Verbal Release of Protected Health Information to Designated Persons

Pt. Name: _____

Address: _____

_____

City State Zip

MRN: _____

DOB: _____ SEX: _____

BY SIGNING THIS FORM, I ACKNOWLEDGE THAT I AM REVOKING A PRIOR AUTHORIZATION THAT I COMPLETED TO GRANT PERMISSION TO UT SOUTHWESTERN MEDICAL CENTER TO COMMUNICATE IN PERSON OR BY TELEPHONE WITH THE FOLLOWING PERSONS, DESIGNATED BY THE PATIENT, TO ASSIST WITH THE PATIENT'S HEALTH SERVICES.

I UNDERSTAND if I revoke the prior authorization, it will not have any effect on any actions taken by UT Southwestern Medical Center prior to the processing of the revocation.

The designated person(s) to be revoked:_____

_____

_____	_____	_____	_____
Signature of Patient	Printed Name of Patient	Time AM/PM	Date

IF PATIENT HAS A LEGAL REPRESENTATIVE, COMPLETE THE FOLLOWING:

Printed Name of Patient:_____

Printed Name of Legal Representative: _____

Relationship to Patient:_____

By signing this authorization, I certify that I have legal authority to serve as the above named patient's legal representative.*

_____	_____	_____
Signature of Legal Representative	Time AM/PM	Date

**Proof of legal authority may be required. For more information on qualifications to serve as a patient's legal representative, see UT Southwestern Medical Center's Guidelines for Legal Representatives.*

This Section for Internal Use Only

Date revocation received: _____ Date revocation processed: _____

Name of employee processing request:_____