BOISE STATE UNIVERSITY

HEALTH SERVICES

HIPAA Revocation of Authorization Form

Patient name: ______________________________ Date of birth: ______________

Previous name (if applicable): ______________________ University ID: ______________

Email Address: ______________________________ Phone: ______________

This form is used to revoke or to confirm revocation of a previously authorized disclosure. You may make this revocation at any time by giving written notice to the Privacy Officer listed on our Notice of Privacy Practices. You may only revoke an authorization you made for yourself or your minor child. This revocation of authorization will not affect any action we took in reliance on the initial authorizations prior to receiving this notice.

I, ______________________, revoke my authorization for the use and/or disclosure of the protected health information described below. I understand that this revocation will not affect any action Health Services or others took in reliance on my previous authorization and before receipt of this written revocation.

If available, a copy of the original authorization should be attached.

Copy of authorization attached:

Yes

No (Complete section below)

Date of authorization (If known):

This Revocation of Authorization applies to the following protected health information:

Specific description of information to be revoked. (This would be the information you authorized to be released. Examples: All health information, Medical Mental Health Evaluation, Psychiatry and Treatment, Sexual Health (Gyn, STI tests and Treatment), Testing Summary, Summary Letter, etc.):

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Person/Organizations authorized to provide the information. (This could be a provider, clinic, hospital and/or health insurance company. Examples: Health Services, St. Luke's Hospital, etc.)

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Person/Organization authorized to receive the information. (Please provide the full name (or other means to identify) of the person or business you want to revoke authorization to receive the information you authorized for release. Examples: Self, Jane Smith, John Smith, St. Luke's Hospital, etc.)

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To be valid, this Revocation of Authorization must be signed and dated by the person listed on the top of this form. Parents may sign the Revocation of Authorization if it relates to the release of health information on their minor child. If you have signed this form in the capacity of the patient's person representative, such as a parent, guardian, or power of attorney, you must also include your name and relationship to the person listed at the top of this form.

I, ______________________, have had full opportunity to read and consider the contents of this Revocation of Authorization.

____ ______________________

Printed Patient Name **Date**

____

Patient Signature

If this Revocation of Authorization is being signed by a personal representative on behalf of the individual, please complete the following:

____ ______________________

Printed Name of Personal Representative **Date**

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Relationship to Individual

After you have signed the Revocation of Authorization, keep a copy for your records and send a copy to Julia Beard, Privacy Officer, Health Services, 1910 W. University Dr., Mail Stop 1351, Boise, ID 83706 or via email healthservices@boisestate.edu attention to Julia Beard.

If you have questions about completing this form, contact us or our Privacy Officer at 208-426-1459.