Texas Health's Health Information Exchange Services
Revocation of Authorization

Name of Patient_____ Date of Birth_____
Address _____
_____

I, the undersigned, hereby revoke the authorization I had previously provided which allowed Texas Health's health information exchange services to release my health information to other health information exchange participants.

I understand that this revocation does not apply to any action my healthcare provider has taken in reliance on the authorization signed earlier.

This revocation applies to releases by the health information exchange services only and does not revoke any other authorizations to release information that I have provided to my healthcare providers.

I understand that this request revokes future access to medical information through the health information services from visits to my providers (past and present) and is effective after the date of this signed revocation.

After receiving this form, the Interoperability team may take up to 72 hours to finalize your revocation.

Date: _____ Signature: _____
Patient or Legally Authorized Representative

_____
Printed Name of Patient or Legally Authorized Representative

_____ _____
For departmental use: MRN/Acct # Relationship to Patient

A "legally authorized representative" is: 1) a legal guardian, 2) an agent authorized in a medical power of attorney or directive to physicians, 3) an attorney appointed by a court, 4) an attorney retained by the patient or the patient's legally authorized representative, 5) a parent or legal guardian of a minor, or 6) a person authorized under the Texas Consent to Medical Treatment Act: the patient's spouse, adult child, a parent of the adult patient, a person clearly identified in advance of incapacity to act for the patient, the nearest living relative, or a member of the clergy. NOTE: Written evidence of legally authorized representative status must be presented to the provider prior to release of any information.

Internal Use Only:

HIE document list flag added. Date: _____ Name: _____

Route the form to Texas Health Resources Interoperability team after adding the HIE document list flag with a status of "Patient Refused".

Address:	600 E. Lamar Blvd, Suite 301 Attn: ITS Interoperability Team Arlington, Texas 76011
Fax:	(682) 236-6487
Send encrypted e-mail to:	THRHIE@texashealth.org

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Texas Health Resources®

PATIENT IDENTIFICATION

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