Weill Cornell Medicine

Authorization To Use or Disclose Protected Health Information (PHI) Revocation Request Form

If possible, please revoke the Authorization to use or disclose PHI for the patient named below:

Patient Name: ____ MRN#: _____________________

Street: ____ DOB: ______________________

City: ____ Phone: ____________________

ST: ___________________________ Zip: _____________________ NYP#: _____________________ (if available)

The authorization was signed on the following date: ___________________________________

The authorization was given to the following WCMC provider/practice:

Name: ____

Address: ____

City, State, Zip: ____

I understand that if the provider has already carried out my wish to release medical information, he or she will be unable to revoke the authorization. (Attach copy of original authorization, if possible.)

____ Patient/Representative Signature

_______________________ Date

If the patient listed above is a minor or is unable to sign, and you are a parent, legal guardian, or personal representative signing on behalf of this patient, please sign above and complete the following:

____ Print name

_____________________________________ Relationship to patient

WCMC, please indicate date completed: ____________, retain this form in the patient's file, and provide a copy to the requestor