Lincoln Internal Medicine Associates

REVOCATION OF AUTHORIZATIN FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION.

Revocation of Authorization

This notice revokes the authorization to use and disclosure of protected health information for:

____
Patient Name (Please Print or Type)

That was signed on:

____
Date of Previous signed consent

Effect of Revocation

Protected health information that is collected on or after the date on which this form is received by Lincoln Internal Medicine Associates will not be used or disclosed by Lincoln Internal Medicine Associates for the purposes specified on the authorization that is revoked.
This revocation of authorization will not limit the ability of Lincoln Internal Medicine Associates to seek payment for services that it provided under an earlier authorization, nor to meet legal obligations related to those services, nor will it affect uses or disclosures under the revoked authorization that occurred prior to the effective date of this revocation.

Other consequences of revoking authorization include:

____

____

Effective Date of Revocation

The revocation of authorization to use or disclose protected health information is effective ____/____/____

Signature

____
Name of Patient (Print or Type)

____
Signature of Patient Date

____
Signature of Patient Representative

____
Relationship of Patient Representative to Patient