EAST CAROLINA UNIVERSITY
HEALTH CARE COMPONENTS

Revocation of
Authorization for Use or Disclosure of Protected Health Information

Name:_____ Date of Birth:_____

Address:_____ Phone Number:_____

I **revoke** my previous authorization for _____ to use or
(Print Name of ECU Health Care Component or Provider)
disclose a copy of my specific protected health information (PHI) identified below to:

_____
(Print Name of Person(s) or Entity(s) Authorized to Receive PHI)

_____
(Print Address and Phone Number of Name or Entity Authorized to Receive PHI)

By initialing the spaces below, I specifically **revoke** authorization for the use or disclosure of the following health information created and maintained by a Health Care Component of East Carolina University (ECU):

□ Entire Medical Record
□ Pathology Reports
□ Clinic Notes
□ Genetic testing information
□ HIV/AIDS related information
□ Other_____
□ Lab Reports
□ Radiology Reports
□ Dental Records
□ Drug & Alcohol treatment information
□ Mental health information

If the box below is selected, no other boxes may be checked; a separate form must be completed.
□ Psychotherapy Notes

Important Information Regarding this Revocation

1. Signing or refusing to sign this revocation will not affect your ability to obtain treatment.
2. This revocation will not apply to any action that has already been taken upon your previous authorization to use or disclose PHI.
3. Upon request, a copy of this signed revocation of authorization will be sent to you.

I have read and understand this information. I am the patient or I am the patient's personal representative and authorized to act on behalf of the patient to sign this document to revoke a previous authorization to use or disclose PHI under the above terms.

_____ _____
Signature of Patient Date

_____ _____
Signature of Person Signing of Behalf of Patient Please Print Name

_____
Legal Relationship to Patient

Please return this request to:
ECU Privacy Officer

East Carolina University
Physicians Quadrangle N
600 Moye Blvd
Greenville, NC 27834

Internal Use Only

□ Revocation request sent to: _____

(Print Name of ECU Health Care Component)

By:

_____

Signature **Title/Location** **Date**