Notice of Revocation of Authorization for the Disclosure of PHI

Patient Name: ______________________________Date of Birth: ________________Record # _________

I, ______________________________(patient or personal representative) hereby revoke my authorization for Gerald Champion Regional Medical Center ("GCRMC") to disclose the health information of the above named individual to the entity/person noted below. This revocation effectively makes null and void any permission for disclosure of information expressly given by the prior authorization dated ________________________. I understand that any actions based on this authorization before the date of revocation will not be affected.

Specified information is to be disclosed to the following entity or individual:

____

(Name of indicated entity or individual to receive protected health information)

____

(Address)

____

(City, state, zip)

Name of Patient or
Personal Representative *(PLEASE PRINT)*____

Signature of Patient or
Personal Representative: ____ Date ________________
(If Personal Representative, include a description of authority to act for patient)

Signature of Witness: ____ Date: _______________

Please submit this form directly to:

Director – Health Information Management
Gerald Champion Regional Medical Center
2669 North Scenic Drive
Alamogordo, NM 88310

If you have any questions, please contact the Director of HIM directly at 575-443-7800

For GCRMC Use Only: Date that this revocation was received by GCRMC___________________________

Action taken and date ____

Gerald Champion
Regional Medical Center
Our Family Caring For Yours

Patient Identification

GCRMC Form# MRHIPAA3 5-12