Group Health Cooperative
of South Central Wisconsin

Request for Revocation of Previously Authorized Documents

Purpose: The purpose of this form is to provide the GHC-SCW patient with the opportunity to exercise his/her right to revoke a previously-submitted request for release of documents.

_____ _____ _____
Patient Name (Please print) GHC# DOB

_____
Street Address City State Zip

_____ _____
E-Mail Address Phone Number

Information About Previously-Submitted Request for Record Authorization:

Date I signed the authorization:_____

Party to Whom the Information Was to Be Disclosed:_____

Type of Information That Was to be Disclosed:_____

Authorization for Revocation:

I, _____ hereby revoke the authorization to release information that I provided to GHC-SCW that allowed the use and disclosure of my protected health information (PHI) as I described above. I understand that that this revocation does not apply to any action that GHC-SCW has taken in reliance on the authorization I signed earlier. This revocation does not revoke any and all previous authorization to release information that I have provided to GHC-SCW.

Special Provisions: Describe any special provisions or instructions regarding this revocation:

(Indicate "none" if not applicable:_____

Signature

_____ _____
Signature of Patient or Personal Representative Date of Signature

Upon completion of form, return to the GHC-SCW Privacy Officer using one of these options:

USPS Mail	Fax	PDF as E-Mail Attachment
GHC-SCW Privacy Officer 1265 John Q. Hammons Drive Madison, WI 53711	(608) 662-4965	privacy@ghcscw.com

Please direct questions to the GHC-SCW Privacy Officer at (608) 662-4899