Retina & Vitreous Consultants of Wisconsin Revocation of Authorization to Disclose Protected Health Information
45 CFR § 164.508

A previously authorized release of protected health information may be revoked at any time using this form. When referring to a previous authorization, please be as specific as possible to ensure accuracy. You may request to view your previous release forms, if needed, to complete the information requested below.

A revocation of authorization will **not** be honored if:

1. Retina & Vitreous Consultants of Wisconsin has taken action in reliance on the authorization; or

2. The authorization was obtained as a condition of obtaining insurance coverage. In this situation, other law provides the insurer with the right to contest a claim under the policy.

Patient Name: ____
(Last, First, MI)
Date of Birth: ________________ Social Security Number: ____________

In the previous release, I had authorized records to be released to:

____
(Name of Doctor/Clinic/Program)
____
(Street Address)
____
(City) (State) (ZIP)

Date I authorized release (if known): _____/____ /_____

Type of information I had authorized to be released: *(Check all that apply)*

_____Medical Visit Notes _____Immunizations _____X-ray
_____Lab Results _____Rehab Notes _____HIV Test Results
_____ALL

Other comments:
____
____

I hereby revoke my prior authorization. I understand that this revocation is not effective for disclosures made based upon reliance on my prior authorization.

________________________________ Date: ____________________
(Signature of Patient)
________________________________ Date: ____________________
And when applicable signature of:
______ Parent of Legal Guardian
______ Next of Kin of Deceased
______ Power of Attorney

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