Private Health Information (PHI) Authorization Revocation

Note: Any covered participant over the age of 18 requires a separate Authorization Form to be completed.

Section A – Individual Authorization Use and/or Disclosure of Protected Health Information (PHI)			
Participant Name			
Mailing address			
City, State, Zip Code		**Telephone**	
Social Security #			

Section B – Statement of Revocation

I revoke my previous authorization for your use and/or disclosure of my protected health information (PHI) as described below.

I understand that this revocation of my authorization will **NOT** affect any action you or others took in reliance on my authorization before they received this written notice of my revocation.

Copy of authorization attached: ☐ Yes ☐ No

Section C – Description of Authorization Revoked *(Complete this section if authorization NOT attached)*

Date of authorization (if known) _____

Protected Health Information: *The revoked authorization authorized use and/or disclosure of the following PHI.*

Entities or Persons Authorized to Use or Disclose: *The revoked authorization authorized the following persons and/or organizations (or classes of persons and/or organizations), including us, to make use of or to disclose the protected health information described above.*

Entities or Persons Authorized to Receive and Use: *The revoked authorization authorized the following persons and/or organizations (or classes of persons and/or organizations), including us, to receive and/or use the protected health information described above.*

Section D – Individual's Signature

Print Name: _____

Signature: _____ Date: _____

If this revocation is signed by a personal representative on behalf of the individual, complete the following:

Personal Representative's Name: _____

Signature: _____ Date: _____

Relationship to Individual: _____

AFTER YOU HAVE SIGNED THE AUTHORIZATION, KEEP A COPY FOR YOUR RECORDS.

Submit to: **Kazdon, Inc.**
Claims Administrator
PO Box 29927
Austin, TX 78755

Fax: **(512) 340-0406**