

Revocation of Authorization for Release of Medical Information

You have the right to revoke a previous authorization for release of health information.

To do so you must fill out this form and return it to the Health & Counseling Center (accepted in person, via fax, by email, or mail).

| | | | |
|----------------|--|-------------|--|
| Patient Name: | | Date: | |
| Date of Birth: | | Student ID: | |

I wish to revoke the authorization for release of protected health information previously provided that allowed the Health & Counseling Center to disclose my protected health information to:

| | |
|---|--|
| Name of Person/Facility: | |
| Address of Person/Facility: | |
| Phone Number of Person/Facility: | |
| Date of Original Release of Information being revoked (if known): | |

This Revocation is given freely and with the understanding that:

- I understand that this revocation of my authorization can only apply to future disclosures of my protected health information and it cannot cancel or retroactively apply to disclosures or actions made under the previous authorization before the receipt of this written notice of my revocation.
- I understand that disclosure of health information may be required by law in certain limited instances.
- This revocation becomes effective when it is received by the Health & Counseling Center.

Patient Signature: _____ Date: _____

Please return this form via email, fax, or in-person to:

University of Portland Health & Counseling Center
 5000 N Willamette Blvd.
 Orrico Hall, upper level
 Portland, OR, 97203

Email: hcc@up.edu
 Phone: 503-943-7134
 Fax: 503-943-7199

For Staff Use Only

Date Received: _____ Received by (Initials): _____