

**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.

(Signature of Patient) Date: _____

And when applicable signature of: Date: _____

____ Parent of Legal Guardian
____ Next of Kin of Deceased
____ Power of Attorney