Navicent Health Form

Z26189 Revocation of Authorization for Release of Health Information

Patient Information:

Patient's Name: ____
Last First Middle Date of Birth

Home Address: ____
Street City State Zip Code

Home Phone: (________) ____________________ Cell Phone: (________) ______________________________

I ____, give permission for the following Navicent Health Facility:
(Patient/Legal Guardian)

____
(Navicent Health Facility/Practice Name)

To Revoke the Release of Health Information Authorization completed to disclose health information to:

Person/Organization/Agency: ____

Address:____

Date Authorization was completed: ____

Statement of Revocation:
I give permission to revoke the following authorizations previously given to Navicent Health to disclose my Protected Health Information as specified in said requests, that has not already expired, been previously revoked, or to the extent that action has been taken in reliance on it.

Please note: To revoke a Payment and Reimbursement Authorization, please contact the Business Office at 478-633-1130. This revocation cannot be done on this form as this form only revokes authorization for medical records not billing records.

Disclaimer:
I understand that this revocation will not affect any of the action taken before the receipt of this written revocation. A patient or the patient's legally authorized representative may not revoke a disclosure that is required for the purposes of making payment to Navicent Health for care provided to the patient if the bill has not been paid in full, or for any disclosure required by law.

____
Signature of patient or patient's representative

____:____________________
Date Time of Revocation AM/PM

FOR NAVICENT HEALTH STAFF ONLY: ☐ Authorization stamped "Revoked" ☐ Scan with revoked authorization

Entity-Department Name: System-HIM	**Revision Date: 11/6/19**
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