ST. JOHN'S EPISCOPAL HOSPITAL, SOUTH SHORE

WRITTEN NOTICE OF REVOCATION
OF
AUTHORIZATION TO USE AND DISCLOSE PROTECTED HEALTH INFORMATION

Individual's Name: _____
Last First Middle

Home Address: _____

_____

Home Telephone: _____ **Date of Birth:** _____

I hereby revoke the authorization generated by me on _____ [insert date], a copy of which is attached to this form.

I understand that this revocation will not be valid until received by the St. John's Episcopal Hospital (the "Hospital") or where the Hospital has already acted in reliance upon my authorization.

_____ _____
Signature of Patient (or Personal Representative) Date

_____
Printed Name of Personal Representative

Relationship to Patient: _____

Instructions to Patient (or Personal Representative):

Mail, fax or bring this Written Notice of Revocation to the Hospital's Department of Risk Management/Corporate Compliance at 327 Beach 19th Street, Far Rockaway NY 11691. By facsimile : (718) 869-8588. If you have any questions regarding this form, you may contact the Director of Risk Management in person, by telephone at (718) 869-7665.

For St. John's Episcopal Hospital, South Shore Internal Use Only:

The date on which this Written Notice of Revocation was received by the Hospital is: _____. A copy of this Written Notice of Revocation shall be placed in the patient's medical record.