Seattle Children's Hospital and Seattle Children's Primary Care Group
Revocation of Authorization

You have the right to revoke your Authorization to release Patient Health Information. To do so, this form must be completed and returned to Seattle Children's Health Information Integrity department.

Patient Name: _____ Date of Birth: _____ /_____ /_____
Last First Middle Month Day Year

I, as the patient or legal representative of the above patient, hereby revoke (cancel) my previous authorization and withdraw my permission for Seattle Children's to share records and/or communicate with:

Person/Organization Name:	Approximate Date Signed:
_____	_____

Person/Organization Address:

_____
Street Address City State Zip Code

I understand that:

- This revocation will not be in effect until Seattle Children's Health Information Integrity department has confirmed receipt and is allowed 5 business days to process.
- This revocation applies to the future sharing of information. Information that has already been shared with my written permission or for continuity of care purposes cannot be recalled.
- Health information will be disclosed when required by law; for example, to report infectious diseases.
- Signing this cancellation is voluntary; I do not need to sign this form to assure treatment.

_____ _____
Patient/Legal Representative Name **Relationship to Patient**

_____ _____
Patient/Legal Representative Signature **Date Signed**

Signature of minor patient (13-17 years of age) is required to revoke an authorization, if the following information was previously included on prior authorization: conditions relating to reproductive care, sexually transmitted infections (including HIV/AIDS) (age 14 and older), mental health conditions (age 13 and older), and drug and alcohol abuse diagnosis or treatment (age 13 or older).

_____ _____
Signature of Minor Patient **Date Signed**

After completing this form, you may submit by:

- Giving the form to clinic or unit staff. They will forward it to the Health Information Integrity department.
- Mailing or faxing the form to Health Information Integrity department (see address/fax below).
- Emailing your request to HealthInformation@seattlechildrens.org.

Seattle Children's Primary Care Group

Seattle Children's
HOSPITAL · RESEARCH · FOUNDATION

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REVOCATION OF AUTHORIZATION

PATIENT LABEL