HIPAA Authorization Revocation Form

Note: Any covered participant over the age of 18 requires a separate Authorization Form to be completed.

Section A – Individual Authorization Use and/or Disclosure of Protected Health Information (PHI)	
Patient Name	
Mailing Address	
City, State, Zip Code	
Phone Number	

Section B – Statement of Revocation

I revoke my previous authorization for your use and/or disclosure of my protected health information (PHI) as described below.

I understand that this revocation of my authorization will NOT affect any action you or others took in reliance on my authorization before they received this written notice of my revocation.

Copy of authorization attached: ☐ Yes ☐ No

Section C – Description of Authorization Revoked (Complete this section if authorization is NOT attached)

Date of authorization (if known) / /

Protected Health Information: *The authorized use and/or disclosure of the following PHI.*

Entities or Persons Authorized to Use or Disclose: *Authorized persons and/or organizations, including WNYBC, to make use of or to disclose the protected health information described above.*

Entities or Persons Authorized to Receive and Use: *Authorized persons and/or organizations, including WNYBC, to receive and/or use the protected health information described above.*

Section D – Individual's Signature

Patient Name (Print): ______________________________________

Signature: ____ Date: __________________

If this revocation is signed by a personal representative on behalf of the patient, complete the following:

Personal Representative Name: ______________________________

Signature: ____ Date: __________________

Relationship to Patient: ____

After you have signed the revocation form, keep a copy for your records and send original to:

Western New York BloodCare
Attn: Compliance Officer
1010 Main Street, Suite 300
Buffalo, NY 14202

Fax: 716-218-4010
Attn: Compliance Officer