Arise. | AUSTIN MEDICAL CENTER

AND ARISE PROVIDER-BASED ENTITIES

# Revocation of Authorization for Release of Protected Health Information

I hereby revoke my authorization dated _____ and previously given to Arise Austin Medical Center (AAMC) to disclose my Protected Health information. I understand this revocation will not affect any of the actions taken before the receipt of the 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 the hospital for health care provided to the patient.

_____ _____

Printed Patient Name Date of Birth

_____ _____

Social Security Number MRN

Date(s) of Service_____

_____ _____

Signature of patient or patient's representative Date

_____ _____

Printed name of patient representative Relationship to patient

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