



Chapel Hill 1829 East Franklin St., Bldg 400 Chapel Hill, NC 27514
Charlotte 6911-100 Shannon Willow Road Charlotte, NC 28226
Raleigh 2605 Blue Ridge Road, Suite 225 Raleigh, NC

PATIENT AUTHORIZATION TO REVOKE THE RELEASE OF PRIVATE HEALTH INFORMATION

Patient: \_\_\_\_\_ DOB: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code \_\_\_\_\_

The patient retains the right to revoke authorization in writing, except to the extent that action has been taken in reliance on the original signed authorization or, if applicable, during a contestability period. In order for the revocation of this authorization to be effective, NC Neuropsychiatry must receive the revocation in writing. All revocations must be sent to NC Neuropsychiatry to the attention of Medical Records and are not effective until received by this office.

I do hereby request that the authorization to disclose health information of

\_\_\_\_\_ to \_\_\_\_\_
(Name of Patient) (Name of recipient of released information)

which was signed by \_\_\_\_\_ on \_\_\_\_\_
(Name of Person Who Signed Authorization) (Date of Signature)

be rescinded, effective \_\_\_\_\_.
(Today's Date)

I understand that any action taken on this authorization prior to the rescinded date is legal and binding.

\_\_\_\_\_. (Patient or Legal Guardian Signature) \_\_\_\_\_ (Date)

\_\_\_\_\_. (Printed Name of Legal Guardian, if applicable)

\_\_\_\_\_. (Witness Signature) \_\_\_\_\_ (Date)