TUSCOLA COUNTY HEALTH DEPARTMENT (TCHD)
REVOCATION FORM
FOR AN AUTHORIZATION FOR THE USE OR DISCLOSURE OF
PROTECTED HEALTH INFORMATION

I _____hereby revoke my authorization
(Signature required below)

For the use and disclosure of my Protected Health Information dated _____.

Specific type of information being revoked: _____
_____
_____

Person/Facility initially requested to release information (include address if known): ____
_____

Person/Facility initially intended to receive information (include address if known): ____
_____

I understand that this revocation does not affect disclosures or uses of my information made before the date of this revocation. I also understand that information already disclosed pursuant to the revoked authorization may be subject to re-disclosure by the recipient and may no longer be protected by this rule. I also acknowledge that this revocation will not affect any authorization provided by me to obtain insurance coverage, or if other law provides the insurer the right to contest a claim or the policy.

☐ I am requesting that my personal health information not be released to my health insurer/health plan for services that I have paid the full charges out of my own pocket, in lieu of having my health insurance/health plan billed.

_____ _____
Signature (Client) Date Signature (Authorized Representative) Date

_____
Description of Authorized Representative's
Printed authority to sign for the client:

_____ _____
Signature (Witness) (Date)

Note* upon completion this form should be attached to the original Authorization