REVOCATION OF AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

La Hacienda Treatment Center, P.O. Box 1, Hunt, TX 78024, Phone: (800) 749-6160, Fax: (830) 238-6119

Please read this entire form before signing and complete all the sections that apply to your decisions relating to the disclosure of protected health information.

Patient Name _____
Last First Middle

Address _____

City _____ **State**_____ **Zip** _____

Phone (_____)_____ **Date of Birth** Month _____ Day _____ Year _____

Statement of Revocation:

I hereby revoke the following authorization(s) previously given to La Hacienda Treatment Center to disclose my Protected Health Information as specified in said request(s), that has not already expired, been previously revoked, or to the extent that action has been taken in reliance on it.

Please note: To revoke a Payment and Reimbursement Authorization, please contact the Business Office at (830) 238-4222; this revocation cannot be done on this form as this form only revokes authorization for medical records, not billing records.

Check all that apply:

☐ I hereby revoke ALL Active Authorizations on File (not already expired)

☐ I hereby revoke my authorization(s) addressed to Person/Healthcare Organization Name:

_____

_____

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Disclaimer: I understand that this revocation will not affect any of the action taken before the receipt of this written revocation. A patient or the patient's legally authorized representative may not revoke a disclosure that is required by law. I further understand that said revocation does not begin until received at La Hacienda Treatment Center.

_____ _____
Patient Signature/or Personal Representative Date