REVOCATION OF UNIVERSAL AUTHORIZATION FOR THE RELEASE OF SENSITIVE MEDICAL INFORMATION

Organization: ____________________

Patient Name: ____________________
Address: ____________________
____
Birthdate: ____________________
Medical Record No.: ____________________

I hereby ***revoke*** any prior Universal Authorization permitting Geisinger[1] and any other entity (past, present or future) that uses the Geisinger shared electronic health record (EHR) from making any further use or disclosure of my protected health information (PHI) related to substance abuse disorder, inpatient/involuntary mental health treatment records, and/or HIV/AIDs related treatment and testing records except as required or permitted by state and federal law.

I understand that this may result in providers outside that do not use the Geisinger shared EHR losing access to the medical information, and may impact coordination of care between my providers.

I understand this revocation is not effective until Geisinger receives it.

I am revoking this because (optional):

Patient signature: ____________________ Date/Time: __________

If a patient is a minor under age 18 (unemancipated) or if patient is unable to give consent, parent or legal guardian must complete the following.

Parent/Legal Representative signature: ____________________ **Date/Time:** __________

Relationship to patient/legal authority to sign: __________

Return to: **Health Information Management**
Department of Release of Medical Information
MC 13-11
100 North Academy Avenue
Danville, PA 17822

Internal Use Only

Initials

________ Date/Time received: ____________________
________ Change patient's UA status in Cadence to revoked.
________ Submit revocation latter for scanning into record.

[1] The term "Geisinger" shall refer to the entire health care system comprised of Geisinger Health ("GH") as parent and all subsidiary corporate entities.