Radiology Ltd.

Radiology Ltd. P.L.C., & RLC, LLC

HIPAA REVOCATION OF AUTHORIZATION FORM

Purpose: This form is used to revoke or to confirm revocation of a previously authorized disclosure. You may make this revocation at any time by giving written notice to a Privacy Contact listed on our Notice of Privacy Practices. You may only revoke an authorization you made for yourself or your minor child. This revocation of authorization will not affect any action we took in reliance on the initial authorization prior to receiving this notice.

SECTION A: Individual revoking the authorization

This section is used to identify the individual who is the subject of the information, usually yourself. (If you are a parent, you may also revoke any authorization you made for the release of health information for your minor child.)

Name:_____ Social Security Number:_____

Address:_____ Date of Birth:_____

_____ Telephone Number:_____

_____ E-Mail Address:_____

SECTION B: Individual's statement of revocation

I revoke my authorization for the use and/or disclosure of the protected health information described in Section C below. If available, a copy of the original authorization should be attached.

I understand that this revocation will not affect any action Radiology Ltd., PLC, RLC, LLC, or others took in reliance on my previous authorization and before receipt of this written revocation.

Copy of authorization attached:

☐ Yes

☐ No (complete section C.)

SECTION C: Description of authorization revoked (complete if authorization not attached)

Date of authorization (if known): ____/____/____

This Revocation of Authorization applies to the following protected health information:

Specific description of information to be revoked. (This would be the information you authorized to be released. Examples: *"All information necessary to coordinate treatment and payment for my health care needs,"* or *"All claims and benefit information for my hospital stay in February YYYY."*)

_____

_____

Person/Organizations authorized to provide the information. This could be a provider, clinic, hospital and/or health insurance company. Examples: *"City of Portland Health Plan,"*

_____ _____

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Person/Organizations authorized to receive the information. Please provide the full name (or other means to identify) of the person or business you want to revoke authorization to receive the information you authorized for release. Examples: *"Clara Smith, wife,"* or *"XYZ Auto Insurance".*

_____ _____

_____ _____

SECTION D: Individual's signature

To be valid, this Revocation of Authorization must be signed and dated by the person listed in Section A. Parents may sign this Revocation of Authorization if it relates to the release of health information on their minor child(ren). If you are signing this form in the capacity of the patient's personal representative, such as a parent, guardian or power of attorney, you must also include your name and relationship to the person listed in Section A.

I, _____, have had full opportunity to read and consider the contents of this Revocation of Authorization.

Signature: _____ Date: _____

If this Revocation of Authorization is being signed by a personal representative on behalf of the individual, please complete the following:

Personal Representative's Name:
Relationship to Individual: _____

_____

AFTER YOU HAVE SIGNED THE REVOCATION OF AUTHORIZATION, KEEP A COPY FOR YOUR RECORDS and send to

Crystal C. Atwell, HIPAA Privacy/Security Officer,
Radiology Ltd., 677 N.Wilmot Rd.,
Tucson, AZ. 85711
or via email crystal.atwell@radltd.com

If you have questions about completing this form, contact us our HIPPA Privacy/ Security Officer at 520.545.1798