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| ou-logo | **The University of Oklahoma** |  |
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**Revocation of Request for Restrictions on Use and Disclosure of**

**Protected Health Information – Health Sciences Center**

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| --- | --- | --- | --- | --- | --- | --- |
| I \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, hereby revoke my Request for Restriction on Use and Disclosure of PHI, effective on the date of my signature. I understand that my Revocation may take up to two weeks to process. I understand that this Revocation applies to any and all Requests for Restrictions I may have been granted by any University of Oklahoma Health Sciences Center. | | | | | | |
| |  |  |  |  |  | | --- | --- | --- | --- | --- | |  |  |  |  |  | | **Signature of Patient, Parent, or Authorized Legal Representative\*** | |  | **Relationship to Patient** |  | **Date** |   **\*May be requested to show proof of representative status**  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  For Clinic Use Only: | | | | | | |
| Copy Approval To: | | | | | | |
|  | [X] | Billing | | | | |
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| Revocation Processed by: | | | | | | |
|  | | |  |  |  |  |
| Clinic/Department Signature | | |  | Title | | Date Processed |