| MICHIGAN MEDICINE<br><br>**Patient Authorization Revocation** | MRN:<br>NAME:<br>DATE OF BIRTH: |
|---|---|

Date: / /

To the Release of Information Unit:

To request revocation of any previously authorized release of my health information, I must complete this entire form **OR** notify UMH Release of Information in writing with a letter. The letter must be signed and include my full name, date of birth, medical record number, phone number, and the forms (and dates) I am requesting to revoke. I understand that if the letter does not include all the required items listed, there could be a delay in processing my request, and my health information could be released.

Please note: A revocation request is not a request to restrict disclosure of your protected health information (PHI). You have a right to request a restriction under HIPAA. But, with one exception involving disclosure to a health plan, Michigan Medicine is under no obligation to agree to a restriction request. By policy, Michigan Medicine does not agree to restrictions that could impede a patient's treatment or that cannot reasonably be implemented.

This form must be either mailed or faxed to the Revenue Cycle Mid-Service (HIM), Release of Information Unit at 3621 S. State Street 700 KMS Place, Bay 11 – Mid-Service, Ann Arbor, MI 48108-1633 **or** fax (734) 936-8571.

Last Name: _____First: _____Middle: _____

Maiden: _____ Date of Birth: _____

Phone Number: _____ UMH Medical Record Number (MRN): _____

I request confirmation of this request sent to me by: ☐ MyUofMHealth ☐ Email ☐ US Mail

I am requesting the revocation of the following previously submitted authorizations. (Please include the date I signed the form I now seek to revoke.):

____ HIM ROI Authorization (form 70-10015) with Signature Date: _____
(initial)

____ Family & Friends Form Out-Patient (form 70-10010) with Signature Date: _____
(initial)

____ Care Everywhere Prospective Authorization (form 70-10159) with Signature Date: _____
(initial)

____ Authorization to View Electronic Patient Information (form 70-10012 ) with Signature Date: _____
(initial)

Other form: _____ with Signature Date:_____
(name form)

_____ ____/____/_____
**Signature of Patient or Legally Authorized Representative** (if patient is a minor or unable to sign) **DATE** (mm/dd/yyyy)

_____
**Printed Name of Legally Authorized Representative** (if patient is a minor or unable to sign)
**Relationship to Patient:** ☐ **Spouse** ☐ **Parent** ☐ **Next-of-Kin** ☐ **Legal Guardian** ☐ **DPOA for Healthcare**



| 70-10352 | VER: A/23<br>HIM: 02/23 | Medical Record | UNIVERSITY OF MICHIGAN HEALTH | HIM ROI Authorization - Revoked |
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