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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. |
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| **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 |
|  | **[ ]**  |  |
|  | **[ ]**  |  |
|  |  |  |
| [ ] Revocation Processed by:  |
|  |  |       |  |       |
| Clinic/Department Signature |  | Title | Date Processed |