CenterWell
Senior Primary Care

6350 West Colonial Drive
Orlando, FL 32818
PH: 866-222-0403

Revocation of Authorization of Protected Health Information

PATIENT INFORMATION

Last Name	First Name
Address	
City	State / Zip Code
Phone Number	Date of Birth

I hereby request _____ to revoke/cancel
Clinic Name

The current authorization on file, which permits the following person(s) or entity listed below to access my protected health information:

Name	Relationship

SIGNATURE REQUIRED

- I understand that signing and submitting this form ends my previous authorization to release information t the individual(s) or entity listed above.
- I understand that this revocation will be effective three (3) business days after receipt of this form.
- I understand that the revocation **will only apply to further disclosures or actions** regarding my protected health information and does not cancel actions or disclosures made while the disclosure was previously in effect and valid.
- I will retain a copy of the revocation form for personal reference, and the original will be kept on file in the medical record for the period of time designated for such retention.

Print Name: _____ Date _____

Signature: _____

*Name of Interpreter/Translator (if required) _____ Phone Number _____

OFFICE USE ONLY

Office Personnel (Print Name) _____ Date _____