



Use this form to revoke an authorization previously given.

**Section A: - Individual revoking authorization**

Please read and complete the following information:

NAME		DAYTIME PHONE NUMBER	
ADDRESS	CITY	STATE	ZIP
DATE OF BIRTH	CONTRACT NUMBER		

**Section B: Revocation**

**I revoke my authorization for the use and disclosure of the protected health information (PHI) described in the original authorization (or as described in Section C).**

Is a copy of your original authorization attached?  Yes  No (Please complete Section C.)

I understand that this revocation *will not* affect actions taken in accordance with my original authorization prior to receipt of this written revocation.

**Section C: Description of authorization you are revoking** (Please complete or attach a copy of the original authorization.)

Date of authorization (if known): \_\_\_\_\_

Describe in detail the persons or entities and information that the original authorization applied to (providers, dates of treatment, type of service, etc.):

**Disclosure by the Family Health Centers of BCN ( BCN):**

The authorization allowed BCN to disclose the PHI described above.

**Disclosure to the Family Health Centers of BCN:**

The authorization allowed BCN to receive and use the PHI described above

**Section D: Signature**

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

*If you are not the patient, please sign and write today's date below, then check the box that describes your relationship to the patient. If you are not the parent of the patient, please attach proof of your relationship to the patient. NOTE: An authorization is required if you are not the personal representative.*

Print Name of Personal Representative: \_\_\_\_\_

Signature of Personal Representative: \_\_\_\_\_ Date: \_\_\_\_\_

Parent  Legal Guardian  Power of Attorney  Executor  Other \_\_\_\_\_

***WE WILL PROVIDE YOU A COPY OF THIS SIGNED REVOCATION***

**Return this form to the Family Health Center where you receive your care:**

<b>Family Health Center – Creyts Road</b> 1401 S. Creyts Road Lansing, MI 48917	<b>Family Health Center – Lake Lansing</b> 1525 W. Lake Lansing Road East Lansing, MI 48823	<b>Former patients of Fashion Square, Essexville, and Midland Family Health Centers return forms to:</b> Family Health Center – Creyts Road 1401 S. Creyts Road Lansing, MI 48917
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## **INSTRUCTIONS FOR COMPLETING THE REVOCATION**

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### **Section A: Individual revoking the authorization**

- 1) Patient's first and last name
- 2) Patient's full street address, including city, state and ZIP code
- 3) Patient's date of birth.
- 4) Patient's telephone number, including area code

### **Section B: Revocation**

- 1) Check yes if you have attached a copy of the original authorization
- 2) Check no and complete Section C if you have not attached a copy of your authorization.

### **Section C: Description of authorization revoked (Complete if authorization is not attached.)**

- 1) Provide the date that the authorization was signed (if known)
- 2) List in detail the information that the authorization applied to such as providers, dates of treatment, types of service, etc.
- 3) Check whether or not the FHC was authorized to disclose your protected health information, or if the member had authorized others to disclose his or her PHI to the FHC.

### **Section D: Signature**

- 1) The patient is required to sign and date the authorization revocation. If the individual that signs the form is a personal representative, the individual must specify his or her relationship to the patient.
- 2) The personal representative must print his/her name and detail relationship to the patient and authority to sign. If the personal representative is someone other than the parent of a minor child, written proof is required.

The signer will receive a copy of the completed revocation of authorization form via return mail.  
The operating unit that processed the authorization will retain the original.