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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:  Revocation Processed by | | | | | |
|  |  |  |  |  |
| Clinic/Department Signature |  | Title | | Date Processed |

University of Oklahoma Health Sciences Center, University Privacy Official, P. O. Box 26901, Oklahoma City, OK 73129