State of Alaska
Department of Health and Social Services

REVOCATION OF AUTHORIZATION FOR RELEASE OF INFORMATION

I hereby request that the authorization to release the information of ______________________________________
(Printed Name of Client)

signed on ____________________________ by ____
(Date of original authorization) (Printed name of person signing original authorization)

for the release of information described as ____
(Description of information released on original authorization)

____

be revoked, effective ______________________. I understand that any action taken on this authorization prior to the
(Date)

revocation date is legal and binding. I understand that I may request a copy of this signed revocation.

Client SSN, Record ID or Other ID (if known)	Client Date of Birth (if known)
Signature of Client or Personal Representative (Or Witness if signature is by mark)	Date
Printed Name of Personal Representative or Witness	Description of Personal Representative's Authority
Printed Name of Staff Member (indicate Division as well)	Signature of Staff Member

NOTE: This revocation must be attached to the original authorization and the date of the revocation entered on the front side of the original authorization form in the space provided.

A PHOTOCOPY OF THIS REVOCATION IS AS VALID AS THE ORIGINAL

INSTRUCTIONS:

The elements of this form described below (1-8) and marked with an asterisk (*) MUST BE COMPLETED. There are NO exceptions. Incomplete revocation forms are invalid and WILL NOT BE PROCESSED!

1. **Printed Name of Client ***: Clearly print the name of the individual whose information was authorized to be released by the original authorization.

2. **Date of Original Authorization *:** The original authorization must be located and the actual signature date of the original authorization entered here.

3. **Printed Name of Person Signing Authorization ***: Clearly print the name of the client, client's authorized representative or witness (if client signs revocation with a mark rather than signature).

4. **Revocation Effective Date *:** Generally, this would be the date the revocation is signed. **The date CAN NOT be a date in the past!**

5. **AT LEAST ONE identifier other than client name must be present on the revocation form *:** At least one of the following identifiers MUST be indicated on the form in the appropriate space provided. More than one additional identifier is preferred, if known:

    - **Client SSN**
    - **Record ID**
    - **Date of Birth**
    - **Other ID**

6. **Signatures & Dates ***: The individual whose PHI is being released or requested should sign and date the form. If the individual is a minor, or is otherwise not able to sign the form, the individual's authorized representative or witness should sign and date it. If an authorized representative signs the form, the representative's "legal authority" to act on the part of the individual must verified first and then described in the appropriate space. Legal authority includes but is not limited to a parent who signs the form for a minor child or an individual who has power of attorney over the affairs of the individual whose PHI is being released or requested.

7. **Printed Name of Staff & Signature of Staff ***: The DHSS or business associate employee accepting the revocation should print their name & division and sign the form.

8. Attach the completed revocation to the original authorization and enter the date of the revocation in the space provided at the bottom of the original authorization. If the Privacy Official for your division is maintaining original authorizations, then this form should be forwarded to your Privacy Official.

9. If requested, provide a copy of the revocation (and authorization) to the client or client's representative.

QUESTIONS?

Contact the [Division Name] Privacy Official at (907) 999-9999 or the DHSS Privacy Official at (907) 465-2150 with any concerns you may have.

FOR DHSS & BUSINESS ASSOCIATE USE ONLY

Use this section to document any additional comments or issues surrounding this revocation.

Date	Staff Name & Division	Comments
________	____________________	____
		____
________	____________________	____
		____
________	____________________	____
		____