Revocation of Authorization to Release Protected Health Information (PHI)

FLORIDA DEPARTMENT OF ELDER AFFAIRS
4040 Esplanade Way
Tallahassee, Florida 32399

I, **[Name of Individual]**, hereby revoke the authorization for **DOEA** to use and disclose my protected health information to carry out treatment, payment or health care operations that I signed on **[Date of Original Authorization]**. _____ However, **DOEA** may use and disclose my protected health information after I revoke my authorization, if **DOEA** treated me and I stated on the authorization form that **DOEA** could use and disclose my protected health information for treatment, payment, or health care operations prior to treatment. **DOEA** may no longer use or disclose my protected health information without my authorization after **DOEA** has treated me, obtained payment, and is no longer required to use or disclose my protected health information.

_____
Individual's Signature and Date

REVOCATION OF AUTHORIZATION TO RELEASE INFORMATION

I, **[Name of Individual]** hereby revoke the authorization to release information I provided to **DOEA** that allowed **DOEA** to use and disclose my protected health information as I outlined on **DOEA's** authorization form, which I signed on **[Date]** for release of my protected health information to **[Name of Person or Facility]**). I understand that this revocation does not apply to any action **DOEA** has taken in reliance on the authorization I signed earlier. This revocation does not revoke any and all previous authorizations to release information that I have provided to **DOEA**.

_____
Individual's Signature and Date

SPECIAL PROVISIONS

In this section, the individual should outline any special provisions regarding the revocation of the authorization.

_____
_____
_____
_____
_____
_____
_____
_____

_____
Individual's Signature and Date