State of Illinois
Department of Human Services - Division of Mental Health - Developmental Disabilities

REVOCATION OF AUTHORIZATION TO DISCLOSE HEALTH INFORMATION

The Health Insurance and Portability Act of 1996 (HIPAA), and the Mental Health and Developmental Disabilities (MHDD) Confidentiality Act provides an individual the right to revoke a previous authorization to disclose information at any time. By completing this form you are requesting a restriction to any further disclosures of your personal health information.

I, _____

(Print your name, address and phone number)

_____

hereby revoke any previous authorizations to disclose my protected health information.

I understand that by signing below, revokes previous authorizations to disclose my protected information.

I understand that no revocation of this consent shall be effective to prevent disclosure of records and/or communications until it is received by the person otherwise authorized to disclose records and communications.

I further understand that the revocation will only apply to further disclosures or actions regarding my personal health information and cannot 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.

_____ _____
Signature of Individual Date

_____ _____
Signature of Witness Date

Office Use Only

_____ _____
Designee/Privacy Officer Signature Date

Print Form Reset Form