WellPower

Request to Revoke an Authorization to Release Protected Health Information (ROI)

The completed form can be returned to the HISM Department by email at **HISM@wellpower.org**, by fax at **(303) 504-6504**, or in person/by postal mail **attention to HISM** at **4141 East Dickenson Place (Office 170), Denver, CO 80222**.
If you have questions, please call (303) 504-6510.

Person Served Information

Please complete the following information about the person whose health information has been authorized for disclosure.

First Name: _____ M.I.: _____ Last Name: _____

WellPower ID#: _____ Date of Birth: _____ *(mm/dd/yyyy)*

Requestor Information

If you are requesting on behalf of the person in services, please fill in your information below. Supporting documentation of your legal authority to make this request must be included. Leave blank if not applicable.

First Name: _____ M.I.: _____ Last Name: _____

Organization: _____ Relationship: _____

Your Contact Information

Street Address: _____ City, State: _____ Zip: _____

Email: _____ Phone: _____

Request Details

Please provide the details of which Authorization(s) to Release Protected Health Information is/are being revoked:

_____

_____

_____

_____

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_____

Statement of Understanding

Pursuant to the HIPAA Privacy Regulation, you have a right to revoke a previously signed authorization to disclose protected health information. You may make this revocation at any time by giving written notice.

- You may only revoke an authorization you made for yourself, your minor child, or if you are legally authorized to do so.
- You may only revoke authorizations that are on file with WellPower.
- This revocation will not affect any action WellPower took in reliance on the initial authorization prior to receiving this notice.
- The revocation will take 2 to 3 business days from the day it has been received for it to come into effect and be reflected in your health record.

By signing below, I confirm that I have read and understand the above information and that I revoke the above listed authorization(s) for any further use and/or disclosure of my protected health information. If available, a copy of the original authorization is attached.

X _____ _____

Requestor Signature Signature Date