University of Colorado Colorado Springs

Patient Name(s): _____

Medical Record #: _____

Date of Birth: _____

Contact Phone #: _____

REVOCATION OF AUTHORIZATION

Revocation From: Please check all that apply.

☐ Aging Center (719) 255-8002 (719) 255- 8006 Fax	☐ Center for Active Living (719)255-8004
☐ Peak Nutrition Clinic (719) 255- 7524	☐ Primary Care Clinic (719) 255- 8001 (719) 255- 8044 Fax
☐ Veterans Health and Trauma Clinic (719) 255- 8003 (719) 255-8075 Fax	☐ Helen and Arthur E. Johnson Beth-El College of Nursing and Health Sciences, Nurse-Family Partnership© (719) 255-8049

I, _____, (patient's name) want to revoke the authorization that I gave to

_____ (list name of person or unit or department of the UCCS Designated Health Care Components to which you gave authorization, if known) on or about _____ (date) which gave UCCS HealthCircle Clinics the authority to give my information to

_____ (name of recipient of information, if known).

Signature of Patient or Authorized Representative **Date of Signature**

_____ _____

Printed Name **Relationship to Patient (if applicable)**

_____ _____