PURDUE UNIVERSITY
REQUEST TO REVOKE AUTHORIZATION

Instructions:

1. Please enter the information requested below and mail or fax this form to the appropriate department or clinic at Purdue University.

2. The request will be processed by the department or clinic and a letter will be sent to you indicating that the authorization has been revoked and the effective date of the revocation.

3. If your intention is to modify an existing authorization, the authorization must be revoked and a new authorization executed. First, use this form to revoke the original authorization. You may use Purdue's authorization form, found at: http://www.purdue.edu/push/HIPAA/FormsProcedures/General/files/authorizationtouseordisclose.docx, to execute a new authorization.

Note: If you have any questions regarding the completion of this form or about this request, please contact the department or clinic to which you sent the form.

Please revoke my authorization originally signed on __________________________
date original authorization signed

authorizing the use or disclosure of my protected health information by:

____________________________________________________________________________________
Purdue department or researcher

for disclosure to, if applicable:

____________________________________________________________________________________
entity to receive information from disclosing entity above

____________________________________________________________________________________
date revocation request sent

____________________________________________________________________________________
individual or legal representative printed name relationship to individual, (if not individual)

____________________________________________________________________________________
individual or legal representative signature