



Revocation Of Authorization For A Release Of Information By Group Health Cooperative

Name

Consumer Number

Date of Birth

CHART BASE

I hereby revoke the authorization signed by me on _____,
(Date of original authorization)

and submitted to _____
(Group Health clinic, hospital or other facility)

directing Group Health Cooperative to release healthcare information to:

(Organization/Provider)

I understand that this request does not apply to any disclosures:

- Already made in reliance upon my previous authorization,
- Made for the purpose of obtaining insurance, or
- Made as required by law.

Date

Signature of patient
or legally recognized representative

Relationship to patient if not patient

Date received by Group Health Cooperative clinic: _____

Hospital Record or Outpatient Medical Record / Correspondence Section