Centura Health®

Revocation of Patient Authorization for Third Party Access to Patient Portal
CHCR-015 rev. 06/14

Patient Name Bar Code Label
or

Patient Name:_____

Date of Birth:_____

MR# / Acct#:_____

P O R T A L R E V O K E P T

Revocation of Patient Authorization for Third Party Access to Patient Portal

Name of Facility/Practice: _____

Patient Information (please complete all applicable fields)			
First Name:	Middle Name:	Last Name:	Date of Birth:
Street Address:	City:	State/Providence:	Zip:
Phone:	Email:		Last 4 of Social Security #:
Driver's License/State-Issued ID#: *(must include a copy of your ID with this form)*			

By signing below, I hereby authorize Centura Health to revoke access to the individual listed below to "MyCenturaHealth" patient portal so my protected health information can no longer be viewed by him/her:

Third Party Information			
First Name:	Last Name:	Sex (M/F):	Date of Birth:
Street Address:	City:	State/Providence:	Zip:
Phone:	Email:		Relationship to Patient:

Original Date of Request for the Authorization: _____

Acknowledgement: I understand that uses and disclosures of my protected health information may have been made to this third party individual in reliance upon my previous signed Patient Authorization to Grant Third Party Access to "MyCenturaHealth" Patient Portal form. I further understand that this revocation does not apply retroactively and will not affect any actions taken prior to receipt of this request.

Signature of Patient/Legal Representative: _____ **Date:** _____ **Time:** _____

If Legal Representative, Print Name: _____ Relationship to Patient:_____

Centura Health Use Only:

Verification: ☐ Driver's License #: _____ ☐ Other Appropriate ID: _____

Individual Who Received Request: _____ Date Request Received: _____

Medical Record Number / Account Number: _____ /_____

Completion Date: _____