Revocation of Records Authorization

JPS Health Network
Fort Worth, Texas

Name of Patient: _____ Date of Birth: _____

Address: _____

Phone and/or Email: _____

I, the signer, am canceling the consent. The consent let JPS Health Network's Health Information Exchange (HIE) release my health records.

I know my records were shared based on my old consent. My request to cancel goes into effect when this signed form is processed.

I know, the Data Integrity team takes up to 72 hours to complete the request.

This consent is for the HIE services. It does not cancel other consents to release records that I have given. I know HIE will not be able to access my records in the future.

Date: _____ Signature: _____
Patient or Legally Authorized Proxy

_____
Printed Name of Patient or Legally Authorized Proxy

_____ _____
For Departmental Use: MRN/Acct # Relation to Patient

A "legally authorized representative/proxy" is: 1) a legal guardian, 2) an agent authorized in a medical power of attorney or directive to physicians, 3) an attorney appointed by a court, 4) an attorney retained by the patient or the patient's legally authorized representative, 5) a parent or legal guardian of a minor, or 6) a person authorized under the Texas Consent to Medical Treatment Act: the patient's spouse, adult child, a parent of the adult patient, a person identified in advance of incapacity to act for the patient, the nearest living relative, or a member of the clergy. NOTE: Written evidence of legally authorized representative status must be presented to the provider before the release of any information.

Mail, fax, or email this form to the Data Integrity team.

Address:	Attn: Health Information Management, Data Integrity 1500 S. Main Street Fort Worth, Texas 76104
Fax:	817-702-5700
Send encrypted e-mail to:	him-dataintegrity@jpshealth.org