

The Children's Hospital of Philadelphia

Revocation (Withdrawal) Of Authorization Form

(PLEASE PRINT)

Patient Name: _____ Date of Birth:

Address: _____

Phone Number(s): _____

- On _____ (insert date if known), I signed an authorization permitting The Children's Hospital of Philadelphia to use and/or disclose my medical information.
- I revoke (withdraw) the authorization I provided on that date.
- I understand that The Children's Hospital of Philadelphia may have already taken action based on the authorization I provided and this withdrawal does not change this action.

Signature of Patient/Parent/Legal Guardian

Date

Name of Patient's Personal Representative (as applicable)

Relationship to Patient

Please give this form to:
The Children's Hospital of Philadelphia
HIM Department
34th and Civic Center Blvd.
Philadelphia, PA 19104
http://www.chop.edu/about_chop/hipaa/npp.shtml

(TO BE COMPLETED BY CHILDREN'S HOSPITAL STAFF)

Patient MR#: _____