LABEL

Proxy Revocation Form

You have a right to revoke or remove an authorization for access to your AveraChart. Please complete and sign this form to revoke or cancel an authorization.

Patient Information

Complete this section with information about the patient who wants to revoke proxy access to their AveraChart record.

Name: ____ Date of Birth:______________________

Phone number: ______________________ Last 4 digits of SSN: ___________________

Street Address:_________________________ City:______________State:_____Zip: _________

Proxy Information

Complete this section with information about the individual you no longer authorize to access your AveraChart.

Name: ____ Date of Birth:______________________

Phone number: ______________________ E-mail: _____________________________________

Street Address:_________________________ City:______________State:_____Zip: _________

Patient:

I acknowledge and agree that:

By filling out the sections above and signing this form, I am hereby requesting that the proxy access I previously authorized be revoked. No further access will be allowed. I understand my revocation will be valid upon receipt, but will not affect any action taken before the receipt of this request.

Date:___________ Time:___________ ____

Signature of Patient or Legal Representative

____

If Signed by Legal Representative, Relationship to Patient

Return forms to your health facility.
Attn: Health Information Management

HIM use only *(staff initials)*
____Patient signature verified
____Approved by HIM
____Proxy access revoked
____Form scanned into medical record