Revocation of Authorization to Release Information

I, _____, formally revoke the previous authorization provided to HealthTrust to provide information to a third party. The authorization was provided to release information to:

Name:
Relationship (Please check One): ☐ Spouse ☐ Parent ☐ Employer ☐ Child ☐ Personal Representative ☐ Other: _____

Your Name (printed):	Your Contact Information (Address, Phone, Email):
Your Signature:	Date:

If a legal representative signs on behalf of the individual, a copy of the legal representative's authority must be attached to this form, e.g. Health Care Power of Attorney, Executor/Administrator of an estate.

TO BE COMPLETED BY HEALTHTRUST WORKFORCE MEMBER	
Name of HealthTrust Workforce Member Receiving Form:	Date:

TO BE COMPLETED BY THE HEALTHTRUST PRIVACY OFFICER

HealthTrust is no longer authorized to release information per the previous authorization as of the date entered by the HealthTrust Privacy Officer below.

Privacy Officer (printed):	Date of Original Authorization:
Privacy Officer Signature:	Date Revocation Effective (receipt of this form):

The HealthTrust Privacy Officer has contacted the following Departments regarding this revocation:

☐ Enrollee Services ☐ Benefits and Wellness ☐ Benefits and Coverage ☐ Human Resources ☐ Other: _____

Additional Comments:
