NOTICE OF REVOKED AUTHORIZATION

Consumer Name (PRINT ONLY): _____

Date of Birth: _____

Last 4 Digits of SS#: _____

I hereby revoke my prior authorization which allowed Matrix Medical to share and exchange treatment records and information to:

_____

(Name of individual, health provider or other entity)

_____ _____

(Address) {Phone Number)

- I understand that Matrix Medical Network cannot be held liable for records and information released prior to this Notice of Revoked Authorization as evidenced by my initials: _____

_____ _____

Member Signature Date

_____ _____

DPOA / Guardian Signature Date

_____ _____

Matrix MN, Medical Records Supervisor Signature Date

OFFICE USE ONLY: This section to be completed when verbal notice or a letter is received.

Notice Provided By: Phone (date)
Letter (date received)
DOS (date)

Reason for Revoking (if provided): _____

_____

_____

_____ _____

Supervisor Signature Date

A copy of this form must be provided to the member or DPOA / guardian who has requested the revocation.

☐ Copy mailed on: _____
☐ Copy faxed on: _____
☐ Copy hand delivered on: _____

- *This form must be stapled over top of the Authorization for Release of PHI form that is Revoked-*