OKLAHOMA DEPARTMENT of CORRECTIONS
Revocation of Authorization for Release of Protected Health Information

You have the right to revoke (end/terminate) your Authorization for Release of Protected Health Information at any time. To do so, you will complete this form and return it to the Medical Services unit. The prior authorization form(s) will no longer be in effect even if the expiration date has not been reached.

Statement of Revocation:

I, _____ hereby revoke the authorization to release protected health information for disclosure of my health information records.

- ❑ All active authorizations to release my protected health information.
- ❑ Specific authorizations to release my protected health information:

Name of authorized recipient: _____
Date of authorization (if known): _____

Name of authorized recipient: _____
Date of authorization (if known): _____

Name of authorized recipient: _____
Date of authorization (if known): _____

Name of authorized recipient: _____
Date of authorization (if known): _____

I understand in the event that medical information has already been disclosed by a valid authorization this information cannot be retracted.

The facility and medical staff are hereby released from any legal responsibility or liability for disclosure of the information I authorized previously.

Inmate Signature: _____ Date: _____

Witness Signature: _____ Date: _____

Inmate Name: (Last, First) ODOC #: