PULMONARY AND CRITICAL CARE ASSOCIATES OF BALTIMORE, P.A.

Authorization Revocation Form

This notice revokes the authorization and disclosure of protected health information for

_____ signed on _____.
(Name of Patient) (Date)

Effect of Revocation

Protected health information that is collected on or after the date on which this form is received by PCCAB will not be used or disclosed by PCCAB for the purpose specified in the authorization that is revoked. This revocation of authorization will not limit the ability of PCCAB to seek payment for services that is provided under earlier authorization, nor to meet legal obligations related to those services, nor will it affect uses or disclosures under the revoked authorization that occurred prior to the effective date of this revocation.

Effective Date of Revocation

This revocation of authorization to use or disclose Protected Health Information (PHI) is effective: _____

Patient:

Address:

Signature of Patient:_____ Date: _____

D.O.B _____