TAB 37
Written Notice of Revocation of Authorization to Use and Disclose Protected Health Information

See attached

DEPAUL FAMILY AND COMMUNITY SERVICES

WRITTEN NOTICE OF REVOCATION OF AUTHORIZATION TO USE AND DISCLOSE PROTECTED HEALTH INFORMATION

Patient's Name:	_____		
	Last	First	Middle
Home Address:	_____		
	_____		
Home Telephone:	_____		

I hereby revoke the authorization created by me on _____ **[insert date]**, a copy of which is attached to this form.

I understand that this revocation will not be valid where DePaul Family and Community Services ("FCS") has already acted in reliance upon my authorization.

By: _____ _____ __, 20__
Signature of Patient (or Personal Representative) Date of Signature

INSTRUCTION: Please provide the following information if the patient's parent or other personal representative will sign this Written Notice of Revocation. The patient must be at least 12 years old to sign this Written Notice of Revocation.

_____
Printed Name of Personal Representative (*if applicable*)

_____
Relationship of Personal Representative to Patient
(*if applicable*)

Instructions to Patient (or Personal Representative):

Deliver this Written Notice of Revocation to the FCS Business Manager by mail to 2219 N. Kenmore Ave., Suite 300, Chicago, Illinois 60614, by fax to 773-325-7781 or by email to DePaulFCS@depaul.edu. If you have any questions regarding this Written Notice of Revocation, please contact the FCS Business Manager by phone at 773-325-7788 or at the addresses or phone numbers in the preceding sentence.

For FCS Internal Use Only:

The date on which this Written Notice of Revocation was received by FCS is: _____ __, 20___. A copy of this Written Notice of Revocation must be placed in the patient's medical record.