



**REVOCATION OF AUTHORIZATION
TO RELEASE PROTECTED HEALTH INFORMATION**

La Hacienda Treatment Center, P.O. Box 1, Hunt, TX 78024, Phone: (800) 749-6160, Fax: (830) 238-6119

Patient Information:

Patient's Name: _____
Last First Middle

Social Security Number: _____ Date of Birth: _____

Home Address: _____
Street City State Zip Code

Home Phone: (_____) _____ Cell Phone: (_____) _____

Statement of Revocation:

I hereby revoke the following authorization previously given to **La Hacienda Treatment Center** to disclose my Protected Health Information as specified in said request (not already expired).

Check all that apply:

_____ I hereby revoke ALL Active Authorizations on File (not already expired)

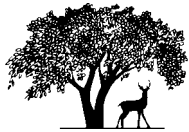
_____ I hereby revoke my authorization addressed to _____

(Name of Individual/Organization on authorization to revoke)

I understand that this revocation will not affect any of the action taken before the receipt of this written revocation. A patient or the patient's legally authorized representative may not revoke a disclosure that is required for the purposes of making payment to the hospital for health care provided to the patient if the bill has not been paid in full, or for any disclosure required by law.

Signature of patient or patient's representative

Date : _____ AM/PM
Time of Revocation



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Patient Information:

Who are you?

Patient's Name: _____
Last First Middle

Social Security Number: _____ Date of Birth: _____

Home Address: _____
Street City State Zip Code

Home Phone: (_____) _____ Cell Phone: (_____) _____

Statement of Revocation:

I hereby revoke the following authorization previously given to **La Hacienda Treatment Center** to disclose my Protected Health Information as specified in said request (not already expired).

What would you like to revoke?

Check all that apply:

_____ I hereby revoke ALL Active Authorizations on File (not already expired)

_____ I hereby revoke my authorization addressed to _____

(Name of Individual/Organization on authorization to revoke)

I understand that this revocation will not affect any of the action taken before the receipt of this written revocation. A patient or the patient's legally authorized representative may not revoke a disclosure that is required for the purposes of making payment to the hospital for health care provided to the patient if the bill has not been paid in full, or for any disclosure required by law.

Sign and Date with Time.

Signature of patient or patient's representative

Date : _____ AM/PM
Time of Revocation