# **REQUEST FOR REVOCATION OF RESTRICTION(S)**

|  |  |  |
| --- | --- | --- |
| *Patient Name* | *Date of Birth* | *MRN* |

# **I hereby revoke the following restriction(s) on the use and disclosure of my protected health information, except to the extent that the HIIM Services and the providers of the Health & Wellness Department of the Pueblo of San Felipe has already taken action in reliance thereon:**

# **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

# **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

# **I hereby revoke the request for restriction of disclosure of my protected health information to the following facility/individual/organization**

# **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

# **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

|  |  |
| --- | --- |
| SIGNATURE OF PATIENT OR AUTHORIZED REPRESENTATIVE *(If Authorized Representative, state relationship)* | DATE |
| SIGNATURE OF WITNESS *(If signature of patient is a thumbprint or mark)* | DATE |

The HIIM Services of the Health & Wellness of the Pueblo of San Felipe is revoking the following restriction(s):

|  |  |
| --- | --- |
| SIGNATURE OF DEPARTMENT DIRECTOR/PRIVACY OFFICER/DESIGNEE | DATE |

**HIIM Statement**

*Public reporting burden for this collection of information is estimated to average 30 minutes per response including time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. An agency may not conduct or sponsor, and a person is not required to respond to, a collection of information unless there is a valid signature and/or authorization from the patient. Please send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden to the:*

*Privacy & Compliance Officer*

*Health & Wellness Department*

*3 Cedar Road*

*San Felipe Pueblo, NM 87001*

*Email: inunez@sfpueblo.com*

SIGNATURE OF CEO OR DESIGNEE

DATE