ALASKA NATIVE MEDICAL CENTER

4315 Diplomacy Drive
Anchorage, AK 99508
Phone: 907-729-3000
Fax: 907-729-3001

Revocation of Authorization for Disclosure of Health Information

I, _____, hereby revoke authorization to
(Name)
Alaska Native Medical Center to disclose information from the health records of:

Patient name: _____

Relationship to Patient: _____

Date of birth: _____

Address: _____
_____

Contact Number: _____

Record Number: _____

covering the period(s) of healthcare:

From _____ to _____
(date) (date)
From _____ to _____
(date) (date)
From _____ to _____
(date) (date)
From _____ to _____
(date) (date)

(2) I understand that disclosures made in good faith may have already occurred in reliance upon my previously issued authorization and that this revocation cannot apply retroactively to such disclosures. I also understand that the disclosure of health information may be required by law in some instances, such as for the reporting of communicable diseases.

(3) The facility, it's employees, officers, and physicians are hereby released from any legal responsibility or liability for disclosure of the information I authorized previously.

Signature: _____
(Patient or Legal Representative)

Date: _____