Revocation of Authorization for Verbal Communications

I, _____, revoke my authorization for the
(Name: Please Print) (Date of Birth)
release of PHI by Valley Obstetrics and Gynecology, their physicians, nurses, and other personnel ("health care providers") to discuss health information, in person or by telephone, with the following **family member or person directly involved in my medical care**.

Name (Please print)	**Phone Number**	**Relationship**

I understand that this signed Revocation applies to future requests for PHI.

I understand this Revocation does not apply to PHI previously released for payment, treatment and healthcare operations or in accordance with a valid Authorization to Release previously received and processed prior to the receipt of this document.

I further understand that I am financially responsible for the payment of all services provided if and after I revoke my authorization to release information for billing purposes.

_____ _____/_____/_____
(Signature of patient or legal representative) (Date)

_____
(Relationship to patient)

This revocation is NOT valid unless it is signed and dated by the patient or their legal representative.