REQUEST FOR REVOCATION OF RESTRICTIONS OF PROTECTED HEALTH INFORMATION FORM

Patient Name _____

Date of Birth _____

Last 4 digits of Social Security Number _____

Address: _____

Phone Number _____

Medical Record Number _____

Addressograph or Label - Patient Name, Medical Record Number

I am revoking the following prior restriction(s):

- ❑ **Restriction of record release to a Payer**
- ❑ **Restriction of record release to an Attorney**
- ❑ **Restriction of record release to a Family member/s**
- ❑ **Restriction of record release to a health information exchange (i.e. HealthShare Exchange, Care Everywhere, etc)**
- ❑ **Other: The information I wish to restrict is: (Please specify)**

_____

_____

You have the right to ask Thomas Jefferson University (TJU), Thomas Jefferson University Hospitals, Inc. ("TJUH"), Jefferson University Physicians (JUP), and TJUH System (Collectively referred to as Jefferson) to revoke your previous request(s) to restrict the use and disclosure of your protected health information (PHI) for Treatment, Payment or Health Care Operations except for uses or disclosures required by law. If you want to exercise this right, your request **must** be in writing.

If you checked the box labeled "Other" please indicate what other information that you requires revocation of your prior request to restrict. Jefferson will review your request and provide you with a written response. Depending upon the nature your request, it may take several days to respond. Until your request has been accepted, Jefferson will continue to restrict your health information in a manner consistent with your prior approved request for restriction, our Notice of Privacy Practices and applicable law.

Patient Signature: _____ Date _____

If other than the patient, specify relationship _____

If document is interpreted

_____	_____	_____
Interpreter Signature	***Print Name***	***Language***
_____	_____	_____
Date	***Position***	***Relationship to Patient***

After you have completed this form, please return it to the Privacy Office by mail or fax transmission at the following address:

Jefferson Health – Center City
834 Chestnut Street, Suite 450
Philadelphia, PA 19107
Attn: Privacy Office
215-503-6300 (t)
215 -503-2213 (f)