Sunrise Ambulatory Surgical Center
5448 South Highway 260 • Suite 100 • Lakeside, AZ 85929
(928)532-3010 • (928)532-1161 *fax*

Authorization Revocation Form

This notice revokes the authorization to the use and disclosure of protected health information for: _____ that was signed on _____

Effect of Revocation
Protected health information that is collected on or after the date on which this form is received by Sunrise Ambulatory Surgical Center will not be used or disclosed by Sunrise Ambulatory Surgical Center for the purposes specified in the authorization that is revoked. This revocation of authorization will not limit the ability of Sunrise Ambulatory Surgical Center to seek payment for services that it provided under an earlier authorization, nor to meet legal obligations related to those services, nor will it affect uses or disclosures under the revoked authorization that occurred prior to the effective date of this revocation.

Other consequences of revoking authorization include:

Effective Date of Revocation

This revocation of authorization to use or disclose protected health information is effective _____.

Patient Name

Patient Address

Signature of Patient _____ Date _____