



## Texas Children's Hospital Revocation of Authorization to Disclose Patient Information

**You have the right to revoke any authorization you have previously given to TCH to disclose your (or your child's) protected health information. If you wish to revoke your authorization please submit this form in writing to TCH. Please be aware that authorizations expire 180 days after the date of signature unless the authorization specifies otherwise, according to state law.**

I previously authorized TCH to disclose information from the records of:

Patient's Name: \_\_\_\_\_ Birth Date: \_\_\_\_\_

Patient's Address: \_\_\_\_\_ Home Phone: \_\_\_\_\_

City, State, Zip: \_\_\_\_\_ Dates of Service: \_\_\_\_\_

Date of original authorization (or approximate date): \_\_\_\_\_

Please provide your address and phone if different from the patient's above.

Address: \_\_\_\_\_ Home Phone: \_\_\_\_\_

City, State, Zip: \_\_\_\_\_

I hereby revoke my authorization for Texas Children's Hospital (TCH) to disclose protected health information as described above.

I understand:

- This revocation will not affect any disclosures by TCH allowed or required by law.
- This revocation applies only to the previously submitted authorization described above.
- This revocation will not affect any disclosures made by TCH in good faith prior to the date that TCH receives and executes this written form.
- I release TCH and its workforce from any legal responsibility or liability for the disclosure of health information previously authorized.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Printed Name: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_

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Mail or deliver  
completed  
form to

} Release of Information, MC 1-3225  
Medical Record Department  
Texas Children's Hospital  
6621 Fannin Street  
Houston, TX 77030

For more information, contact Release of Information  
Medical Record Dept., 832/824-1634, -1651, or -1670.  
or Patient Accounting 832/824-2300.