Student
Health & Counseling

Revocation of Patient Authorization to Release Information

You have the right to revoke any Authorization for Release of Health Information.

To do so, you must fill out this form and return it to UCSF Student Health and Counseling Services (accepted in person or via fax, mail, scanned/emailed).

Fax: (415) 476-6137 email: shs@ucsf.edu

Patient Name _____

My Access ID _____ Date of Birth _____

I wish to revoke my authorization for release of protected health information from UCSF Student Health and Counseling Services to:

_____
(Person or place records should not be disclosed)

Date of previously submitted written release being revoked _____/_____/_____

This revocation is given freely and with the understanding that:

- Disclosures made in good faith may have already occurred based on my previously issued authorization and that this revocation cannot apply retroactively to such disclosures.
- I understand that the disclosure of health information may be required by law in certain limited instances despite this revocation.
- The revocation becomes effective once it is received by SHCS.
- Records already released by the valid authorization cannot be retracted.
- The facility, its employees, officers, and physicians are hereby released from any legal responsibility or liability for disclosure of the information I previously authorized.

Patient's signature _____

Patient's printed name _____

Date Signed _____/_____/_____

For STAFF USE only: Date and time form received

Date: _____/_____/_____ Time: _____