# Revocation of Authorization to Release Protected Health Information

Revocation of Authorization for the Release of information from the following facility (include city/state):

_____

Information Type: ☐ Pharmacy ☐ Vision Center/Optical ☐ Walmart/Sam's Club Optometrist

**What is the Purpose of this Revocation?**
This form is used by you or your personal representative to revoke your previously executed authorization to allow Walmart and Sam's Club Pharmacies, Vision Centers/Optical Centers, or Optometrists (collectively "Walmart") to release Protected Health Information ("PHI") to an individual or organization not otherwise authorized by law to receive this information, as required by the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") and other state and federal privacy laws.

**Section 1: Patient Information**

| Patient Name (last, first, middle initial): | | | Date of Birth (mm/dd/yyyy): |
|---|---|---|---|
| Address: | | | |
| City: | State: | Zip: | Phone: |

**Section 2: Revocation Information**

I, _____, hereby revoke the Authorization to Release PHI which I signed on (date) _____, that allowed the Pharmacy, Vision Center/Optical, or Walmart/Sam's Optometrist at the above listed facility, to release my PHI to the recipient listed below. I understand that this revocation does not apply to any PHI already released by Walmart prior to receipt of this revocation. This revocation does not revoke any other Authorizations that I have previously provided to any Walmart locations.

**Section 3: Recipient of PHI**

| Individual or Entity Receiving Information: | | | |
|---|---|---|---|
| Address: | | | |
| City: | State: | Zip: | Phone: |

**Section 4: Signature**

_____ _____
Signature of Patient or Personal Representative Date

If you have signed this form as a legally authorized representative of the Patient, please print your name and indicate your relationship / authority to act on behalf of the Patient:

_____ _____
Name of Personal Representative (please print) Relationship to Patient (parent, legal guardian, etc.)

**For Office Use Only**

Store/Club Number: _____

Fax this form to Digital Citizenship HIPAA Privacy as directed in POM/VCOG 1610. Date faxed: _____ Initials:_____