Revocation of Authorization to Release Protected Health Information

Revocation of Authorization for the Release of: ☐ Pharmacy ☐ Vision Center/Optical ☐ Care Clinic information from the following facility: (include city and state):

_____

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 Care Clinics (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 Care Clinic 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 HIPAA Compliance as directed in POM/VCOG/COM 1610. Date faxed: _____ Initials: _____