IOWA STATE UNIVERSITY
Thielen Student Health Center

2647 Union Drive
Ames, Iowa 50011
Phone: 515-294-5801
Fax: 515-292-9135

Revocation of
Authorization for Release of Healthcare Information or Consent for Verbal Communication

Patient Information:

Patient Name (Last, First, Middle, Maiden):	
Current Address (including City, State, Zip):	
University ID#:	Date of Birth (MM/DD/YYYY):
Phone #:	Email Address:

I hereby revoke my previously made authorization to disclose healthcare information signed by me on (enter date):_____, and submitted to Thielen Student Health Center (TSHC) directing TSHC to release my healthcare information to the following individual or organization:

Name:
Address (including City, State, Zip):
Phone:
Fax:
Email:

Further, I agree and understand:

1. This request does not apply to any disclosures already made in reliance upon my previous authorization;
2. This request does not apply to any disclosures already made for the purpose of treatment, payment or operations of TSHC; or made as required by law.

Patient's Printed Name

Today's Date (MM/DD/YYYY)

Signature of Patient