REVOCATION OF AUTHORIZATION TO USE AND DISCLOSE CONFIDENTIAL HEALTH INFORMATION

I hereby revoke any and all prior authorizations that I signed in any place at any time entitled ***THE INDIGENT CARE COLLABORATION: Authorization to Use and Disclose Confidential Health Information.***

I understand that it is my right to revoke this authorization, and that my revocation must be in writing and delivered to the ICC to be valid. I also understand that if I wish to re-authorize the sharing of information at a future time, I will need to sign a new authorization form.

I understand that there may be a delay between the time the revocation is received by the ICC and the time that my information is removed from further disclosure, but that this delay will generally not exceed seventy two (72) hours.

_____

Name of Individual | Signature of Individual or Authorized Party | Date

_____

Birth Date | Address | Social Security Number (if available)

_____

(If different from individual) Relationship of Authorized Party to Individual

_____ _____

Witness | Date

For this revocation to be valid, please either mail or hand deliver it to the following address, or give it to any participating ICC provider to mail or hand deliver to:

Indigent Care Collaboration
c/o Application Administrator
2101 IH-35 South, Suite 500
Austin, Texas 78741