Avera

PROX REV

Patient Label

You have a right to revoke or remove an authorization for access to your AveraChart. Please complete and sign this form to revoke or cancel an authorization.

Patient Information

Complete this section with information about the patient who wants to revoke proxy access to their AveraChart record.

Name: _____ Date of Birth:_____

Phone number: _____ Last 4 digits of SSN: _____

Street Address:_____ City:_____State:_____Zip: _____

Proxy Information

Complete this section with information about the individual you no longer authorize to access your AveraChart.

Name: _____ Date of Birth:_____

Phone number: _____ E-mail: _____

Street Address:_____ City:_____State:_____Zip: _____

Patient:

I acknowledge and agree that:

By filling out the sections above and signing this form, I am hereby requesting that the proxy access I previously authorized be revoked. No further access will be allowed. I understand my revocation will be valid upon receipt, but will not affect any action taken before the receipt of this request.

Date:_____ Time:_____ _____

Signature of Patient or Legal Representative

_____

If Signed by Legal Representative, Relationship to Patient

Return forms to your health facility.
Attn: Health Information Management

HIM use only *(staff initials)*

____Patient signature verified

____Approved by HIM

____Proxy access revoked

____Form scanned into medical record