



LABEL

Proxy Revocation Form

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

Patient and/or Member Information

Complete this section with information about the individual who wants to revoke proxy access to their Avera MyChart 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 Avera MyChart.

Name: _____ Date of Birth: _____

Phone number: _____ E-mail: _____

Street Address: _____ City: _____ State: _____ Zip: _____

Patient and/or Member:

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 and/or Member or Legal Representative

If Signed by Legal Representative, Relationship to Patient and/or Member

Return forms to:
Your health facility
Attn: Release of Information
email: AHROI@Avera.org
Fax: 605-322-8200

HIM use only (staff initials)

____ Patient signature verified

____ Approved by HIM

____ Proxy access revoked

____ Form scanned into medical record