Department of Veterans Affairs

REVOCATION OF AUTHORIZATION FOR RELEASE OF INDIVIDUALLY-IDENTIFIABLE HEALTH INFORMATION

PURPOSE: Revocation of authorization for the Department of Veterans Affairs (VA) to release individually-identifiable health information to an outside or non-VA entity

PATIENT FULL NAME
LAST *(Print)*: FIRST: MIDDLE:

DATE OF BIRTH *(MM/DD/YYYY)*:

REVOCATION:

1. I am requesting to discontinue the release of my individually-identifiable health information for:
   - ☐ Immunization reporting.
   - ☐ VA 10-5345 dated *(MM/DD/YYYY)*: _____
   - ☐ Other: _____
2. I understand that you will no longer share any of my individually-identifiable health information with the outside or non-VA entity.
3. I understand that information already released or shared between VA and the outside or non-VA entity prior to this revocation will continue to be used as discussed in the authorization I signed when I gave permission for my individually-identifiable health information to be released or shared.
4. I understand that withdrawing my authorization does not change my relationship with my health care providers, my future care, or have any effect on my VA benefits.

SIGNATURE: This revocation has been explained to me. I hereby revoke the release of my individually-identifiable health information as described in this form.

_____ _____
SIGNATURE OF PATIENT DATE *(MM/DD/YYYY)*:

_____ _____
SIGNATURE OF LEGAL REPRESENTATIVE *(if applicable)* DATE *(MM/DD/YYYY)*:

To Sign for Patient *(Attach authority to sign: Health Care Power of Attorney or Legal Guardian)*

_____
NAME OF LEGAL REPRESENTATIVE *(please print)*