Cameron University
Health Plan

Insert College /Department Name
Insert College/Department Street Address
Insert College/Department City State and ZIP

Revocation of Request for Restrictions on Use and Disclosure of Protected Health Information – Cameron University Health Plan

I _____, hereby revoke my Request for Restriction on Use and Disclosure of PHI, effective on the date of my signature. I understand that my Revocation may take up to two weeks to process. I understand that this Revocation applies to any and all Requests for Restrictions I may have been granted by any Cameron University Health Plan

Signature of Patient, Parent, or Authorized Legal Representative*	**Relationship to Patient**	**Date**

***May be requested to show proof of representative status**

For Department Use Only:

Copy Approval To: If applicable

[X] Billing

☐

☐

☐Revocation Processed by:

Department Signature	Title	Date Processed