REVOCATION & OPT-OUT FORM

Please send completed forms to:

SSM Health Dean Medical Group – Health Information
Attn: Scanning
P.O. Box 259840
Madison, WI 53725-9840
Phone: (608) 294-6244
Toll-Free: (877) 510-1873
Fax: (608) 294-6280

PATIENT INFORMATION

Patient Name: *(or label)* ______________________ Date of Birth: ______________________

Street Address: ______________________ City, State, Zip Code: ______________________

Phone Number: ______________________ Patient MRN *(if known)*: ______________________

REVOCATION REQUEST

Please mark the following authorizations you wish to revoke and provide all known information

☐ Authorization to Release Protected Health Information Date of Original Authorization: ______________

☐ Health Care Power of Attorney (POA) Date of Original Authorization: ______________

☐ LivingWill Date of Original Authorization: ______________

☐ Permission to Treat Minors Revoking Permission to Treat for the following person(s): ______________

☐ Permission for Verbal Communication Revoking Permission for Verbal Communications to the following person(s): ______________

☐ Do Not Resuscitate (DNR) Bracelet Date: __________ Time: __________ Place: ______________

A patient may revoke a DNR Bracelet by destroying or removing the bracelet, or requesting that another person remove the bracelet. Please complete the above section (date, time, and place) to document the revocation.

AUTHORIZATION

I, ____, hereby revoke the document(s) indicated above. I understand that this revocation does not apply to any action taken by SSM Health Dean Medical Group prior to completion of this form. Other regulations may govern Authorizations which are signed as a condition of obtaining insurance coverage.

______________________________ ______________
Signature Date

If this Authorization is signed by a representative on behalf of a patient, please complete the following:

______________________________ ______________________________
Representative's Name Relationship to the Patient

OPT-OUT REQUEST

☐ I wish to OPT-OUT of having my protected health information shared through the following electronic means:

- ☐ Care Everywhere (Epic record sharing service)
- ☐ WISHIN (Wisconsin Statewide Health Information Network)

Reason for Opt-Out Request: ____

____

AUTHORIZATION

I, ____, hereby opt-out of the electronic sharing indicated above. I understand that by making this decision, doctors and caregivers will not be able to access my SSM Health Dean Medical Group health information through the indicated electronic means, except in cases of a medical emergency or as necessary to report specific information to a government agency as permitted by law (for example, reporting of certain communicable diseases or suspected incidents of abuse).

______________________________ ______________
Signature Date

If this Authorization is signed by a representative on behalf of a patient, please complete the following:

______________________________ ______________________________
Representative's Name Relationship to the Patient