Ketchum, Wood & Burgert, chtd. d/b/a

Pathology Associates

Revocation of Consent/Authorization for Disclosure of Health Care Information

Patient's name: _____ Date of birth: _____

SSN: _____ Previous name: _____

Pathology Associates has a detailed document called the "Notice of Privacy Practices". A copy of this document may be found at the Reception desk and on-line at www.kwbpathology.com. This document contains more information about the policies and practices protecting the patient's privacy. I understand that I have the right to read the "Notice of Privacy Practices" before signing this agreement.

In accordance with the terms set forth in the Pathology Associates *Patient Consent* and *Authorization for Release of Health Information* forms:

I understand that I may cancel my consent or authorization in writing at any time.

I also understand that if I revoke my consent, Pathology Associates is not required to provide further health care services to the patient.

My signature below indicates:

(Please initial)

_____ I have been given the opportunity to review Pathology Associates' "Notice of Privacy Practices"

(Please initial all that apply)

_____ I want to revoke my consent to authorize the use and disclosure of the patient's personal health information for treatment, payment, and health care operations

_____ I want to revoke my prior authorization as described below

_____

_____

_____ I choose to **not** allow Pathology Associates to participate in the BBRHIO with regards to the patient's personal health information (Opt-Out)

_____ _____ _____

Patient or legally authorized individual signature Date Time

_____

Relationship to patient, if signed by anyone other than the patient
(parent, legal guardian, personal representative, etc.)

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