Revocation of Authorization

Name:	Request Date:
Mailing Address:	Date of Birth:
City/State/Zip:	Medicaid ID# or Social Security #:

Please provide the following information:

I do hereby request that this authorization to disclose health information of ______________________________
(Name of individual)

signed by ____ on _________________________________
(Name of person who signed the authorization) *(Date of signature)*

be rescinded, effective _________________. I understand that any action taken on this authorization prior to the
(Date)
rescinding date is legal and binding.

____ ______________________
Signature of Individual or Personal Representative Authorized by Law Date

____
Personal Representative's Relationship / Authority

Do Not Write Below this line.

For LDH Use Only

Comments:

____ ______________________
Agency Representative and Title *Date*

LOUISIANA
DEPARTMENT OF
HEALTH