Date: [Date]

To: [Name of Healthcare Provider/Organization]
Address: [Street Address]
City, State, Zip: [City, State, Zip Code]

Subject: Revocation of Authorization to Release Medical Records

Patient Information:
Name: [Patient Full Name]
Date of Birth: [Date of Birth]
Patient Account/ID Number: [Account Number, if known]

To Whom It May Concern,

I am writing to formally revoke my previous authorization for the release of my protected health information. This revocation is effective immediately.

Specifically, I am withdrawing permission for [Name of Person or Entity previously authorized] to access or receive my medical records. This revocation applies to all authorizations signed prior to this date.

I understand that this revocation does not apply to any actions already taken by your facility in reliance on the original authorization before this notice was received. I also understand that this revocation does not affect your ability to use or disclose my information for treatment, payment, or healthcare operations as permitted by law.

Please update my records to reflect that this authorization has been revoked. I request a written confirmation that this letter has been received and processed.

Sincerely,

[Signature]

[Printed Name]