

**SINAI HEALTH SYSTEM**

**REVOCAION OF AUTHORIZATION FOR DISCLOSURE  
OF HEALTH INFORMATION FOR RESEARCH**

1. I hereby revoke my previous authorization(s) to Sinai Health System disclose information from the health records for research purposes of:

Patient name \_\_\_\_\_ Date of birth \_\_\_\_\_

Address \_\_\_\_\_ Telephone \_\_\_\_\_

Title of Research Study: \_\_\_\_\_

Name of Principal Investigator: \_\_\_\_\_

Patient number \_\_\_\_\_

Prior Authorization(s):

Dated: \_\_\_\_\_ Recipient: \_\_\_\_\_

Dated: \_\_\_\_\_ Recipient: \_\_\_\_\_

Dated: \_\_\_\_\_ Recipient: \_\_\_\_\_

2. I request to **revoke** (take back) my authorization to release the following information in research:

Complete health record (s) including all images (x-rays, photographs, etc.)  Mental health care or services

Complete health record (s) excluding all images  Psychotherapy Notes

Discharge Summary

Treatment for alcohol and/or drug abuse

History and Physical Examination

Photographs, videotapes, digital or other images

Consultation Reports

Progress Notes

Aids (Acquired Immunodeficiency Syndrome) or HIV (Human Immunodeficiency Virus) Infection

Laboratory Tests

X-Ray Reports

Other (Please Specify)

Other (Please Specify)

3. I understand that disclosures made in good faith may have already occurred in reliance upon my previously issued authorization and that this revocation cannot apply retroactively to such disclosures. I also understand that the disclosure of health information may be required by law in some instances, such as for the reporting of communicable diseases. I understand that researchers may still use and disclose health information they have already have obtained as necessary to maintain the reliability of the research and to report any adverse effects (bad events) that may have happened to me.
- 4 Sinai Health System, its employees, officers, and physicians are hereby released from any legal responsibility or liability for disclosure of the information I authorized previously.

\_\_\_\_\_  
Signature of Patient or Authorized Party

\_\_\_\_\_  
Date

\_\_\_\_\_  
Printed Name

\_\_\_\_\_  
Relationship to Patient