MID-STATE HEALTH CENTER
101 Boulder Point Drive, Suite 1
Plymouth, NH 03264
P: 603-536-4000 | F: 603-536-4001
midstatehealth.org

REVOCATION OF PERSONAL REPRESENTATIVE FORM

Patient Name: ______________________________ **DOB:** ____________________

MRN #: ______________________________ **Phone Number:** ______________________________

Address: ____

City: ____________________ **State:** ____________________ **Zip:** ____________________

Please Note: This form will revoke the individual listed below as your Personal Representative. By doing so, the individual will no longer be able to act on your behalf in regards to your health care coverage or your protected health information for services provided by Mid-State Health Center. All fields are required. Incomplete or incorrect forms will be returned.

I hereby revoke the following individual as my Personal Representative:

Representative Name: ______________________________ **DOB:** ____________________

Relationship to Patient: ____

I understand that the revocation of my designation of my Personal Representative will be effective upon receipt of this completed form or other method of written revocation, and that the revocation will not be valid in instances where Mid-State Health Center has already acted in reliance upon my designation.

This revocation of Authorization will not limit the ability of Mid-State Health Center to seek payment for services that are provided under an earlier authorization; meet legal obligations related to those services; nor will it affect uses or disclosure under the revoked authorization that occurred prior to the effective date of this revocations.

______________________________ ____________________
Patient's Name (Print) Date

______________________________ ______________________________
Signature of Patient/ Legal Guardian Printed Legal Guardian's Name (If Applicable)

Mail or Fax completed form to:

Mid-State Health Center
Health Information Management
101 Boulder Point Drive, Suite 1
Plymouth, NH 03264
Fax: 603-536-4001

****Health Information Management Use ONLY****	
Form Received By:	Date Completed (MM/ DD/ YYYY):

Date Reviewed: 11/20
By: rje/ab