

**OKLAHOMA STATE UNIVERSITY
CENTER FOR HEALTH SCIENCES**

**REVOCATION OF AUTHORIZATION
FOR USE OR DISCLOSURE OF
HEALTH INFORMATION FOR RESEARCH PURPOSES**

1. I hereby revoke my authorization to Oklahoma State University Center for Health Sciences (“OSU-CHS”) Principal Investigator to use/disclose the protected health information from the health records of:

Name: _____ Date of Birth: _____

Address: _____

Telephone: _____

Participant Number: _____

Study Title: _____

Covering the period(s) of study:

From _____ to _____
(date) (date)

From _____ to _____
(date) (date)

2. I understand that use/disclosures made in good faith may have already occurred in reliance upon my previously issued authorization and that this revocation does not apply to the uses/disclosures that have already been made. I also understand that the law in some instances may require the use/disclosure of health information, such as for the reporting of communicable diseases. This revocation will not stop uses/disclosures required by law.

3. Oklahoma State University Center for Health Sciences, its employees, officers, trustees and physicians are hereby released from any legal responsibility or liability for use/disclosure of the information I authorized prior to this revocation.

Signed: _____
Signature of Patient/Participant Date