Salina Regional Health Center and Affiliates

Revocation of Authorization for Proxy Access to Patient Portal

Name: _____
(Name of Patient)

I **hereby revoke my authorization** for the following individual to use the Salina Regional Health Center and Affiliate's Patient Portal as my proxy.

(Please print)
Name: _____

Date of Birth: _____

Address: _____

Email Address: _____
(Please supply the email address of the person who will be using the patient portal)

I understand that my revocation will not be effective as to uses and/or disclosures already made in reliance upon my previous authorization. I realize that the information used and/or disclosed pursuant to my previous authorization may be subject to re-disclosure and no longer protected by federal privacy laws.

Patient Signature

_____ _____
Signature of Patient Date