



University of South Alabama

**REVOCATION OF AUTHORIZATION FOR DISCLOSURE OF
PROTECTED HEALTH INFORMATION**

I hereby revoke my authorization to University of South Alabama / Principal Investigator to use or disclose the protected health information from the medical records of:

Name: _____ Date of Birth: _____
Address: _____
Telephone: _____
Subject ID No.: _____

IRB Protocol #: _____
Project Title: _____

Covering the following period(s) of study:

From: _____ To _____

I understand that this revocation does not apply to any action the University of South Alabama has taken in reliance on the authorization I signed earlier.

This revocation does not apply to the use/disclosures that have already been made.

Signature of Participant

Date