LOYOLA UNIVERSITY HEALTH SYSTEM
HEALTH INFORMATION EXCHANGE REVOCATION OF CONSENT [001]

I, _____, hereby revoke the consent to allow Loyola University Medical Center ("LUMC") and Gottlieb Memorial Hospital ("GMH"), as applicable (collectively, LUMC and GMH are Loyola University Health System "LUHS") to disclose the below stated patient's health information through a Health Information Exchange. I understand that this revocation does not apply to any action LUHS has taken in reliance on the authorization I signed earlier.

_____ Date:____/_____/____
Patient/Representative Signature

_____
Patient Name (Print)

_____ _____
Patient Date of Birth Telephone Number

_____
Patient Address – City –State –Zip Code

If you are the legal representative for the patient, state your relationship to the patient if the patient is unable to sign or the authority you have to act on behalf of the patient. You must be able to furnish proof of relationship or authority to act for the patient.

Relationship to Patient: _____

Please return this form to:

Director, Medical Records
Loyola University Health System
2160 South First Avenue
Maywood, Illinois 60153
Fax: 708-216-4382