REVOCATION OF PRIOR PEDIATRIC PATIENT PORTAL PERMISSION

Name:_____ **Date of Birth (MM/DD/YYYY):** _____

Address: _____

_____

Phone: _____

E-mail Address: _____

I acknowledge and agree as follows:

1. **I WISH TO REVOKE (change) my prior decision to give permission to other individual(s) to access my medical information in my Archbold patient portal account.**

2. **I UNDERSTAND that by making this election, NONE of the individuals previously granted permission will have access to my patient portal account.**

3. **I UNDERSTAND that this Revocation can only be changed if I complete another Pediatric Patient Portal Permission Form MR 372 while I am under the age of 18.**

4. **I UNDERSTAND it is my personal responsibility to notify other providers if I utilize other patient portals and have given other individuals permission to access my other patient portal accounts.**

5. **I have had an opportunity to have my questions regarding this "Revocation of Prior Pediatric Patient Portal Permission" answered.**

6. **This request can take 5 business days upon receipt by Archbold to be processed and take effect.**

_____ _____

Patient Printed Name **Date**

_____

Patient Signature

Completed and signed Revocation of Prior Pediatric Patient Portal Permission form can be returned to Archbold Medical Center's Health Information Management Department; faxed to 229-227-5183 or 229-227-5181 or mailed to:

Archbold Patient Connect—Archbold Medical Center
c/o Health Information Management Department
900 Cairo Road
Thomasville, GA 31792

For Internal Processing:
Date Received by Archbold: _____
Date Processed _____ HIM Representative's Signature:_____

INFORLSE