hfsc Hospital for Special Care

Patient Authorized Person (Individual/Parent/Guardian) Revocation Form

This form must be completed to revoke patient authorized person access to your patient portal. Please forward to the Health Information Management (HIM) Department.

Patient Information

Patient Name _____ DOB ___/___/___ Email _____

Patient Phone # _____ Cell _____

Address _____ Last 4 Digits of SSN _____

Please list all persons that you are revoking access to view your patient portal via patient authorized person access. Please allow one business day after submission of this revocation request to health information management before the access is deactivated. The designated patient authorized person persons listed below will no longer have access your patient portal records. By signing this form, you understand that any records previously accessed by your designated patient authorized person maybe released by them and may no longer be protected by Hospital for Special Care.

Authorized Person Name	Date of Birth	Relation to Patient	Authorized Person Email Address	Patient Signature (Parent/Legal Guardian if Patient Is a Minor or Legal Representative)	Date

FollowMyHealth® An Allscripts Solution

Health Information Management
p: 860-827-4863 / ROI@hfsc.org

2150 Corbin Avenue, New Britain, CT | 860-223-2761 | www.hfsc.org