

**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**