Department of Veterans Affairs

Revocation for Release of Individually-Identifiable Health Information Through eHealth Exchange

Purpose: Revocation of the electronic exchange of individually-identifiable health information between the Department of Veterans Affairs (VA) and Non-VA Health Care Provider Organizations participating in the eHealth Exchange.

Patient Full Name
Last: (print) _____ **First:** _____ **Middle:** _____

Last four digits of SSN**:** _____

REVOCATION:

1. I am requesting to discontinue my participation in the electronic exchange of my individually-identifiable health information.
2. I understand that you will no longer share any of my individually-identifiable health information with the non-VA health care provider organizations participating in the eHealth Exchange and partnering with VA.
3. I understand that information already exchanged between both parties prior to this revocation will continue to be used as discussed in the authorization I signed when I elected to participate in this electronic exchange of my individually-identifiable health information.
4. I understand that withdrawing from this program does not change my relationship with my health care providers, my future care, or have any effect on my VA benefits.
5. I understand that the VA will respond to this revocation in writing or through the eBenefits Portal informing me that VA has confirmed my request and the effective date of this revocation.

RE-ENROLL: I understand if I decide to re-enroll in the project at a later date, I will be required to start the enrollment process all over again.

SIGNATURE: This revocation has been explained to me. I hereby revoke the sharing of my individually-identifiable health information as described in this form.

_____ _____
Signature of Patient Date

_____ _____
Signature of Legal Representative (if applicable) Date
To Sign for Patient (Attach authority to sign: Health Care Power of Attorney or Legal Guardian)

_____
Name of Legal Representative (please print)