IUPUI
CAMPUS HEALTH
INDIANA UNIVERSITY-PURDUE UNIVERSITY
Indianapolis

REVOCATION OF AUTHORIZATION

If you wish to revoke portions of all of this authorization, please return a signed copy of the form to the address listed below.

I wish to revoke my authorization for:

Patient Portal

____ I no longer wish to have access to the **IUPUI Campus** patient portal.

Communication with Others (emergency contacts)

____ I no longer wish to allow IUPUI Campus Health to communicate with:

NAME	Relationship to you	Telephone Number

Patient/representative's signature

Today's date

Printed name

Date of birth

If not the patient, Representative's name

Relationship

Please return to:

IUPUI Campus Health
Attention: Privacy Official
1140 W. Michigan Street
Suite 100
Indianapolis, IN 46202

FOR OFFICE USE: Date received: _____

Campus Health 1140 W. Michigan Street Suite 100 Indianapolis, IN 46202 (317) 274-8214 fax (317) 274-7657
Indiana University-Purdue University Indianapolis