## Revocation of Communication Authorization

If you wish to revoke portions or all of your communication authorization, please return a signed copy of the form to the address listed below or the front desk of the IUPUI Campus Center (CH).

Please print your initials in the blank lines, complete any requested information and sign and date the form.  If you do not wish to change the communication authorization, leave the line blank and/or strike though the line.

### I wish to revoke my authorization for:

**Communication**

_____ I no longer wish to receive messages via email.

_____ I no longer wish to receive messages via text.

_____ I no longer wish for you to leave messages on my home or cell phone voicemail

**Patient Portal**

_____ I no longer wish to have access to the IUPUI Campus Health patient portal.

**Communication with Others**

_____ I no longer authorize IUPUI Campus Health to communicate my health information with:

| Name | Relationship to you | Telephone Number |
| --- | --- | --- |
| ______________________ | ______________________ | ______________________ |
| ______________________ | ______________________ | ______________________ |

______________________________________ Patient/representative's signature

______________________ Today's date

______________________________________ Printed name

______________________ Date of birth

Please return to:

**IUPUI Campus Health**
1140 W. Michigan Street
Suite 100
Indianapolis, IN 46202

FOR OFFICE USE: Date received: ____________________