Capital Health

Cancellation of Prior Authorized Representative to Access the Patient Portal

Patient's First Name:_____ Patient's Last Name:_____

DOB:_____ Email Address:_____

Street Address:_____

City:_____ State:_____ Zip:_____

Authorized Representative Information

First Name:_____ Last Name:_____

DOB:_____ Email Address:_____

Street Address:_____

City:_____ State:_____ Zip:_____

Relationship:_____ Home Phone Number:_____

Mobile Phone Number:_____ Work Phone Number:_____

I am acknowledging that I have read and understand the information above and I am revoking the above authorized representative access to my personal health information from the patient portal.

_____	_____	_____
Signature of Patient	Date	Time
_____	_____	_____
Signature of Witness	Date	Time

Every effort will be made to process this request within ten (10) business days.

Mail your completed form to:
Capital Health
One Capital Way
Pennington, NJ 08534
Attn: Health Information Management

Or Fax your completed form to:
609-303-4093

**********Internal Usage**********

Dated Completed:_____ Processed By (Name):_____