



**Revocation of Authorization for Use & Release of Individually Identifiable Health Information
for Veterans Health Administration (VHA) Research**

Subject Name (Last, First, Middle Initial):	Subject SSN (last 4 only):	Date of Birth:
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VA Facility (Name and Address):

VA Principal Investigator (PI):	PI Contact Information
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Study Title:

REVOCAION OF AUTHORIZATION:

Your revocation of your authorization must be in writing. You may want to use this form to revoke your authorization as developed for your convenience.

1. I am discontinuing my participation in the research study noted above.
2. I understand the research team may continue to use my information that it has already collected prior to my revocation in order to maintain the integrity or reliability of the research and to the extent that VHA has already acted based on the authorization.
3. I understand that no further information will be collected.
4. I understand that withdrawing from this study 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 research team may need to use my information in order to notify me or government agencies of any health or safety concerns that were identified as part of my study participation.

Research Subject Signature. This revocation has been explained to me and I hereby revoke my research study authorization.

Signature of Research Subject	Date
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Signature of Legal Representative (if applicable)	Date
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To Sign for Research Subject (Authority to sign: e.g. Health Care Power of Attorney, Legal Guardian appointment, or Next of Kin if authorized by State law)

Name of Legal Representative (please print)