Revocation for Use and Disclosure of Health Care Information

Patient's name: _____ Date of birth: _____

Patient's Mailing Address _____

SSN: _____ Previous name: _____

Doctor's Name _____

Practice Name _____

I request and authorize the above listed doctor and practice to revoke by Authorization to Release Health Care Information of the patient named above signed on _____ and on file at the above practice to the following:

Name: _____

Address: _____

City, State: _____ Zip code: _____

This request and authorization applies to health care information relating to the following treatment, condition, or dates of treatment:

_____

_____

Or _____ All health care information

Or _____ Other: _____

_____

I am canceling a previous authorization to the extent allowed by law. I understand that the doctor or practice may have already released information about me after I gave permission. I know that canceling this authorization would not prohibit any release of information by the doctor or practice in reliance on my original authorization.

_____

Signature of patient or patient's authorized representative Date signed

_____

Relationship or status if signed by parent, legal guardian, personal representative, etc.