REVOCATION OF AUTHORIZATION

I hereby REVOKE previous authorization to use or disclose my individually identifiable protected health information as described below.

Patient Name: _____ Date of Birth: _____

Date of Previous Authorization: _____

Provider (Who released information?)

Name: _____ Phone: _____

Address: _____ Fax: _____

Receiver (Who received information?)

Name: _____ Phone: _____

Address: _____ Fax: _____

_____ _____

Signature of patient or patient's legal representative *Date*

_____ _____

Printed name of legal representative *Relationship*

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