REVOCATION SECTION

I do hereby request that this authorization to disclose health information of _____
(Name of Patient)

signed by_____ on _____
(Enter Name of Person Who Signed Authorization) *(Enter Date of Signature)*

be rescinded, effective _____. I understand that any action taken on this authorization prior to the
(Date)

rescinded date is legal and binding.

_____ _____ _____ _____
(Signature of Patient) *(Date)* *(Signature of Witness)* *(Date)*

_____ _____ _____
(Signature of Personal Representative) *(Date)* *(Personal Representative Relationship/Authority)*

VERBAL REVOCATION SECTION

I do hereby attest to the verbal request for revocation of this authorization by _____
(Name of Patient or Personal Representative)

on _____. The patient or his personal representative has been informed that any action
(Date)

taken on this authorization prior to the rescinded date is legal and binding.

_____ _____ _____ _____
(Signature of Staff) *(Date)* *(Signature of Witness)* *(Date)*