

**REVOCACTION 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be rescinded, effective \_\_\_\_\_.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rescinded date is legal and binding.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taken on this authorization prior to the rescinded date is legal and binding.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)*