Revocation of Authorization

Right to Revoke: I understand that I may revoke this authorization to use and disclose my protected health information at any time by giving written notice to the address listed below. I understand that revocation of this authorization will not affect any action the above named entity took in reliance on this authorization before the above named entity received my written notice of revocation.

I hereby revoke this authorization.

_____ _____

Printed name of patient or representative Date

_____ _____

Signature of patient or representative Date