St. Joseph Heritage Medical Group

MRN:_____

Revocation (Withdrawal) Of Authorization Form

(PLEASE PRINT)

Patient Name: _____Date of Birth:_____

Address: _____

_____

Phone Number(s): _____

- On _____(insert date if known), I signed an authorization permitting St. Joseph Heritage Medical Group to use and/or disclose my medical information to,

  _____.
  [Specific Name of Person or Entity]

- I revoke (withdraw) the authorization I provided on that date.
- I understand that this form is intended to terminate my previous authorization to release information.
- I understand that St. Joseph Heritage Medical Group may have already taken action based on the authorization I provided and this withdrawal does not change this action.

_____ _____
Signature of Patient or Personal Representative Date

_____ _____
Print Name of Patient or Personal Representative Relationship to Patient