

VANCOUVER CLINIC
REVOCAION of Authorization to Use or Disclose Information

Medical Record Number (**internal use only**): _____

Patient Name: _____

Date of Birth: _____

I hereby revoke my authorization, dated: _____

Disclose no more information to:

Name (or title), and organization: _____

Address: _____

City/State/Zip: _____

- I understand that this request does not apply to disclosures made prior to receipt of this revocation, or for disclosures that are allowed under, or required by the law.

Patient or legally authorized representative signature

Date

Relationship if signed on behalf of patient

Printed name if signed on behalf of patient