VANCOUVER CLINIC

REVOCATION of Authorization for VANCOUVER CLINIC 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