REVOCATION OF VERBAL AND/OR WRITTEN AUTHORIZATION

SOURCE: __HIM_____

Lakewood HEALTH SYSTEM

Release of Information fax: 205-383-1763

I, _____, hereby revoke the verbal and/or written authorization for
Patient name

_____, effective immediately.
Name of person with current authorization

This will include, but is not limited to, access to receive verbal and/or written medical information on my behalf.

Please print and sign below.

_____
Name of patient

_____
Patient signature

_____
Date/time

This institution is an equal opportunity provider and employer.