

**REVOCAION OF CONSENT**

I revoke my Consent for your use and disclosure of my protected health information for treatment, payment activities, and healthcare operations.

I understand that revocation of my Consent will not affect any action you took in reliance on my Consent before you received this written Notice of Revocation. I also understand that you may decline to treat or to continue to treat me after I have revoked my Consent.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**Adults 18 years of age and older, please list the names of any person that we may share your information with:**

_____	_____
_____	_____

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**FOR OFFICE USE ONLY**

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We attempted

- Individual refused to sign
- Communications barriers prohibited obtaining the acknowledgement
- An emergency situation prevented us from obtaining acknowledgement
- Other (Please Specify)

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

I attest that the above information is correct:

Signature: \_\_\_\_\_ Date: \_\_\_\_\_