



**REVOCAION OF PREVIOUS AUTHORIZATION
TO ALLOW PHYSICIAN ACCESS
TO COMPUTERIZED MEDICAL INFORMATION**

Patient Name: _____

Date of Birth: _____

Telephone Number: _____

I previously gave permission for the following physician(s) or organization(s) to access my electronic record for continuing care purposes, and I understand that this access may have already taken place:

Physician/Organization Name(s): _____

Physician/Organization Address: _____

I now revoke this permission and DO NOT want the above named physician(s) or organization(s) to have access to my electronic medical record from this date forward. Please make this change immediately upon receipt of this notification.

Patient Signature

Date

Return this form to Release of Information Section, HIS/RM at the address at the top of this form.