I hereby revoke my authorization previously given to the Dartmouth Health to disclose my protected health information to:

__________________________________________________________

I understand that this revocation will not affect disclosures made before any Dartmouth Health member organization received this written revocation.

Please check appropriate documents(s):

- CareEverywhere consent form dated ________________________________________________________________________
- Designation of Personal Representative form dated ____________________________________________________________________
- Permission to Share Patient Health Information form dated __________________________________________________________________
- Other ________________________________________________ dated __________________________________________________________________

Signature of Patient or Legal Representative ___________________________ Date __________

Printed Name of Patient or Legal Representative ___________________________ Legal Authority of Representative ___________________________