Restorative THERAPIES
Your advocate for life.

REQUEST TO REVOKE AUTHORIZATION OR RESTRICTION OF PHI

PATIENT INFORMATION

Name: _____ **Date of Birth:** _____
Address: _____ **City:** _____ **State:** _____ **Zip:** _____
Phone #: _____ **Email:** _____

AUTHORIZATION(S) TO BE REVOKED

☐ **All prior authorizations** to release or disclosure protected health information
☐ **Specific authorization** to release or disclosure protected health information (listed below)
Date authorization was signed: _____
Individual(s) and/or Organizations listed on authorization:

Name: _____ Relationship to Patient: _____
Phone #: _____ Email: _____
Address: _____ City: _____ State: ___ Zip: _____
Name: _____ Relationship to Patient: _____
Phone #: _____ Email: _____
Address: _____ City: _____ State: ___ Zip: _____

RESTRICTION(S) TO BE REVOKED

☐ **All prior restriction requests** for protected health information
☐ **Specific restriction request** for protected health information (listed below)
Date restriction request was signed: _____
Individual(s) and/or Organizations listed on restriction:

Name: _____ Relationship to Patient: _____
Phone #: _____ Email: _____
Address: _____ City: _____ State: ___ Zip: _____
Name: _____ Relationship to Patient: _____
Phone #: _____ Email: _____
Address: _____ City: _____ State: ___ Zip: _____

AUTHORIZATION

By signing below, I understand that this revocation request will not affect any actions taken by Restorative Therapies prior to receipt of this signed revocation form.

Signature of Patient or Representative*: _____ **Date:** _____

Name of Representative: _____ Relationship to Patient: _____

**** If not signed by the patient or parent of a minor child, authorizing documentation is required.***

(e.g. Power of Attorney or Legal Guardianship)