FREEMAN HEALTH SYSTEM

Revocation of Authorization for Release of Information Form

On_____, I signed an Authorization to Release
(DATE)
Health Information to _____.

I hearby revoke such Authorization effective immediately. I understand that the health information may already have been disclosed pursuant to and in reliance on my prior Authorization. I also understand that this revocation applies only to the information specifically described in the above-referenced document, and does not affect any prior executed Consents to release information for treatment, payment or health care operations, or any prior executed Authorizations for other information.

Date: _____ _____
Patient or Legal Representative