FAMILY PHYSICIANS OF O'FALLON, P.C.

WRITTEN NOTICE OF REVOCATION OF AUTHORIZATION TO USE AND DISCLOSE HEALTH INFORMATION

Individual's Name: ____
Last First Middle

Home Address: ____
____

Home Telephone: ______________________ **Date of Birth:** ________________________

I hereby revoke the authorization generated by me on ______________ [insert date], a copy of which is attached to this form.

I understand that this revocation will not be valid to the extent that the Practice has already acted in reliance upon my authorization.

____ ________________
Signature of Patient (or Personal Representative) Date

____
Printed Name of Personal Representative

Relationship to Patient: ____________________

Instructions to Patient (or Personal Representative):

Mail or bring this Written Notice of Revocation to the Practice's Privacy Officer or Practice Manager at **310 North Seven Hills Rd., O'Fallon, IL 62269**. If you have any questions regarding this form, you may contact the Privacy Officer or Practice Manager in person or by telephone at (**618**) **624-6181**.

For the Practice's Internal Use Only:

Date Written Notice of Revocation Received by Practice: ________________
Individual Accepting Notice on Behalf of Practice:______________________________
(Privacy Officer/Practice Manager)

*Copy of this Written Notice of Revocation to be scanned into patient's record.

FPO WNRA 041403