PRIMARY CARE PARTNERS

Your Healthcare Destination

Consent Revocation

I, _____ hereby revoke the authorization for the release/disclosure of information/records that allowed Primary Care Partners to use and disclose my medical information as outlined on the authorization form which I signed on ___/___/_____ for release or disclosure of my (or my child's) medical records to _____.

I understand that this revocation does not apply to any action Primary Care Partners has already taken in reliance to the above addressed authorization.

Please outline any special provisions regarding the revocation of the authorization.

_____
_____
_____
_____
_____

I certify that this request has been made voluntarily and by my signature below, I acknowledge that I understand and agree to the above information.

_____ _____

Name of Patient Relationship to patient

_____ _____

Signature of Patient/Legal Guardian Today's Date

Staff initials confirming ID was verified _____
****Patient submitting electronically must attach copy of ID****