Patient Name | Date of Birth | Phone
---|---|---
Address | City | State | Zip

Authorizations to Revoke:
Please mark the following authorizations you wish to revoke and provide all known information.

- [ ] Authorization to Release Protected Health Information
  - Date of Original Authorization: ____________________________

- [ ] Authorization to Release Information via Patient Portal
  - Date of Original Authorization: ____________________________

- [ ] Healthcare Power of Attorney
  - Date of Original Authorization: ____________________________

- [ ] Living Will/Health Care Directive
  - Date of Original Authorization: ____________________________

- [ ] Permission to Treat Minors
  - Date of Original Authorization: ____________________________

- [ ] Permission for Verbal Communication
  - Date of Original Authorization: ____________________________
  - Revoking Permission for the following person(s): ____________________________

Authorization:
I, _________________________________________, hereby revoke the document(s) indicated above. I understand that this revocation does not apply to any action taken by Carris Health Clinics prior to the completion of this form. Other regulations may govern authorizations which are signed as a condition of obtaining insurance coverage.

__________________________       ___________________________
Signature Date

If this authorization is signed by a representative on behalf of the patient, please complete the following:

_______________________________________       ___________________________
Representative’s Name Relationship to Patient

Please send completed forms to:
Carris Health Clinics
ATTN: Health Information
101 Willmar Ave SW
Willmar MN 56201
Phone: 320-231-6711, Fax: 320-231-6323