



Revocation of Authorization for Pullman Family Medicine, PLLC to Use or Disclose Health Care Information

Patient name: _____ Date of birth: _____

Previous name: _____

Revoke my authorization, dated: _____

Disclose no more information to:

Name (or title) and organization: _____

Address: _____ City: _____ State: _____ Zip: _____

I understand that this request does not apply to any uses or disclosures:

- Before Pullman Family Medicine , PLLC gets this revocation, or
- Allowed or required by law.

Patient or legally authorized individual signature

Date

Time

Printed name if signed on behalf of the patient

Relationship
(parent, legal guardian, personal representative)