CONSENT REVOCATION

I,_____hereby revoke the authorization for the release/disclosure of information/records that allowed Melmed Center 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 Melmed Center has 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 (Please print) Today's Date

_____ _____
Signature of Patient/Parent/Legal Guardian Relationship to Patient