Revocation of HIPAA Restriction

I,_______________________________________ hereby revoke the HIPAA restriction that inhibited Melmed Center to use and disclose my medical information as outlined on the authorization form which I signed on _________.
I understand that this revocation does not apply to any action Melmed Center has taken in reliance to the above restriction.

Please outline any special provisions regarding the revocation of the HIPAA Restriction.

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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