



melmed center

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