



# Revocation of HIPAA Restriction

melmed center

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