

PATIENT REQUEST FOR REVOCATION OF RESTRICTION(S) ON HEALTH INFORMATION

Patient Name: _____ Date of Birth: _____

Patient Address: _____

Patient Telephone Number: _____

I hereby revoke the following restriction(s) except to the extent that TGH has already taken action in reliance

thereon: _____

SIGNATURE OF PATIENT OR PERSONAL REPRESENTATIVE
(If Personal Representative, state relationship to patient)

DATE

SIGNATURE OF WITNESS *(If signature of patient is a thumbprint or mark)*

DATE

