REVOCATION OF MY AUTHORIZATION FOR THE USE AND DISCLOSURE OF MEDICAL INFORMATION

I, ___________________________ (patient's name), hereby revoke my earlier authorization of ____ /____ /_____ (date of authorization) which previously allowed Women's Health Associates of Southern Nevada, PLLC to use and/or disclose a copy of my medical records containing individually identifiable health information.

____

Patient Name

____ ______/______/________

Patient/Health Care Agent/Guardian/Relative Signature Date

____

Description of Personal Representative's Authority