Patient name			
MHN	DOB	Age	Gender

Release of Information Revocation Notice

Patient address _____

City _____ State _____ ZIP _____

Home telephone number _____

I hereby revoke the Release of Information Authorization generated by me on

(date: month/day/year) _____ /_____ /_____ to:

Person or organization name _____

Address _____

City _____ State _____ ZIP _____

I understand that this revocation of the Release of Information Authorization will not be valid where Marshfield Clinic Health System has already used or disclosed my health information in reliance upon my authorization.

_____ _____ _____/_____/_____

Patient signature (Person authorized to consent for patient) (Relationship to patient) Signature date (m/d/y)

Send completed form to: Release of Information, Marshfield Clinic Health System, 1000 N. Oak Ave., Marshfield, WI 54449
Fax: 715-221-6992 E-mail: medicalrecords@marshfieldclinic.org

