APPENDIX B

MU Health Care

REVOCATION OF AUTHORIZATION FORM

On _____, I signed an Authorization to Release Health Information

to _____.

I hereby revoke such Authorization effective immediately. I understand that the health information may already have been disclosed pursuant to and in reliance on my prior Authorization. I also understand that this revocation applies only to the information specifically described in the above-referenced document, and does not affect any prior executed consents to release information for treatment, payment or health care operations, or any prior executed Authorizations for other information.

PATIENT NAME: _____ DOB: _____
(Please print)

ADDRESS: _____
(Please print)

SIGNATURE:_____
Patient or Legal Representative DATE

_____
Relationship to Patient