

Millers of Wyckoff, Inc.

**REVOCACTION OF AUTHORIZATION FORM TO RELEASE
PROTECTED HEALTH INFORMATION (PHI)**

I, _____, born on _____, do wish to revoke
my authorization for release of PHI, which was dated on _____
and due to expire on _____.

I do not hold the Pharmacy liable for documentation or communications they may have
already acted upon based on the previously prepared or delivered Authorization Form.

Signature of Patient or Personal Representative

Date Signed

Print Name of Person Signing

Signer's Date of Birth

If signed by the patient's personal representative, explain your authority to act on behalf
of the patient:

Revised 03/11//03 dmm

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