PHYSICIANS INDEPENDENT MANAGEMENT SERVICES, INC.

REVOKE AUTHORIZATION FOR USE & DISCLOSURE OF PROTECTED HEALTH INFORMATION (PHI)

Patient's Name		Birth Date		Social Security #	
Address				Phone #	

I hereby REVOKE authorization from:

to release the health information of:

to:

that was granted for the purpose of:

Type of access granted:

Date

Signature of Patient or Guardian

Relationship to Patient

For Office Use Only

Information Updated By: