Palouse Heart Center
Palouse Pediatrics
Palouse Psychiatry & Behavioral Health
Palouse Pulmonology & Sleep Medicine
Pullman Family Medicine
Palouse Health Center

Revocation of Authorization to Use or Disclose Protected Health Information

Patient name: _____ Date of birth: _____

Previous name: _____

Revoke my authorization dated: _____

Disclose no more information to:

Name (or title) and organization: _____

Address: _____

City: _____ State: _____ Zip: _____

I understand that this request does not apply to any uses or disclosures:

- Before the affiliated office of Pullman Regional Hospital Clinic Network receives this revocation, or
- Allowed or required by law

_____

Patient or legally authorized individual signature Date Time

_____

Printed name if other than patient Relationship (parent, legal guardian, representative)