GRANT COUNTY FIRE PROTECTION DISTRICT NO. 3

Revocation of Authorization to Use or Disclose Health Information

Patient name: _____ Date of birth: _____

Previous name(s): _____

Revoke my authorization, dated: _____

Disclose no more information to:

Name (or title) and organization: _____

Address: _____

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

- Before the District receives this revocation, or
- Allowed or required by law.

_____

Patient or legally authorized individual signature Date Time

_____

Printed name if signed on behalf of the patient Relationship (parent, legal guardian, personal representative)