Revocation of Authorization for Disclosure of Health Information

I hereby revoke authorization to **HELOTES COSMETIC & FAMILY DENTISTRY, PLLC** to disclose information from the dental records of:

Patient name: ____________________________________ Date of Birth: ___________________________

Address: ____

Telephone: ____________________________

Dental Record Number: _________________

Date Of Authorization To Be Revoked: ____

OR

Dates Of Care To Be Covered:

From: _______________________________ To: ____________________________________

From: _______________________________ To: ____________________________________

I understand that disclosures made in good faith may have already occurred in reliance upon my previously issued authorization and that this revocation cannot apply retroactively to such disclosures.

Our office is hereby released from any legal responsibility or liability for disclosure of the information I authorized previously.

____ ____

Signature Patient or Personal Representative | Printed Name Patient or Personal Representative

____ ____

Date | Personal Representative's Authority