HIPAA 1 223
Revocation of Authorization for the Spokane Eye Clinic to Use or Disclose Health Care Information

I, (Patient name): _____ Date of birth: _____

Previous name: _____

Revoke my authorization, dated: _____

Disclose no more information to:

Name and/or organization: _____

Address: _____ City: _____ State: ____ Zip: _____

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

• Before Spokane Eye Clinic, Spokane Eye Surgery Center, Spokane Eye Clinical Research receives this revocation,

• As 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)

When this form is returned to the office your electronic chart will be updated. We will ask you to complete another electronic Friends and Family form at your next visit.