Steinberg Diagnostic
Medical Imaging Centers
"Where Imaging Revolves Around You" SM

REVOCATION OF AUTHORIZATION

I do hereby request that the authorization to disclose health information of

_____
(Name of Patient)
signed by_____ on _____
(Name of Person Signed Authorization) (Date of Signature)

be rescinded, effective _____. I understand that any action taken on this authorization prior to the rescinded date is legal and binding.

_____ _____ _____ _____
(Patient Signature) (Date) (Witness) (Date)

_____ _____ _____
(Personal Representative) (Date) (Personal Representative Relationship)

VERBAL REVOCATION OF AUTHORIZATION

I do hereby attest to the verbal request for revocation of this authorization by _____
(Patient/Personal Representative)

on _____. The patient or personal representative has been informed that any action
(Date)
taken on this authorization prior to the rescinded date is legal and binding.

_____ _____ _____ _____
(Signature of Staff) (Date) (Witness) (Date)