Revocation of Permission Form

Patient Name	Date of Birth	Phone	
Address	City	State	Zip

Authorizations to Revoke:
Please mark the following authorizations you wish to revoke and provide all known information.

- ☐ Authorization to Release Protected Health Information
  - Date of Original Authorization: _____
- ☐ Authorization to Release Information via Follow My Health (Patient Portal)
  - Date of Original Authorization: _____
- ☐ Healthcare Power of Attorney
  - Date of Original Authorization: _____
- ☐ Living Will/Health Care Directive
  - Date of Original Authorization: _____
- ☐ Permission to Treat Minors
  - Date of Original Authorization: _____
- ☐ Permission for Verbal Communication
  - Date of Original Authorization: _____
  - Revoking Permission for the following person(s):_____
    _____

Authorization:

I, _____, hereby revoke the document(s) indicated above. I understand that this revocation does not apply to any action taken by Affiliated Community Medical Centers prior to the completion of this form. Other regulations may govern authorizations which are signed as a condition of obtaining insurance coverage.

_____ _____
Signature Date

If this authorization is signed by a representative on behalf of the patient, please complete the following:

_____ _____
Representative's Name Relationship to Patient

Please send completed forms to:
ACMC Corporate Office
ATTN: Health Information
101 Willmar Ave SW
Willmar MN 56201

Phone: 320-231-6711, Fax: 320-231-6323