TRI-CITY ORTHOPAEDICS

6703 W Rio Grande Ave
Kennewick, WA. 99336
Ph: (509) 460-5588
Fax: (509) 783-5438

821 Swift Blvd
Richland, WA 99352
Ph: (509) 460-5588
Fax: (509) 946-7253

965 Goethals Dr
Richland, WA 99352
Ph: (509) 460-5588
Fax: (509) 943-9521

REVOCATION FOR CONSENT FOR USE AND DISCLOSURE OF PRIVATE HEALTH INFORMATION FOR TREATMENT, PAYMENT AND HEALTH CARE OPERATIONS

Patient Name:_____ Date of Birth _____

SSN: _____ Previous Name (if any) _____

I no longer want Tri-City Orthopaedic Clinic, PSC to use and disclose health care information about me for treatment, insurance billing and payment and health care operations of the clinic.

I understand that:

- This request applies after I sign this document.
- Tri-City Orthopaedic Clinic, PSC may have already taken action based upon my earlier permission.
- Tri-City Orthopaedic Clinic, PSC is allowed by law to use and disclose my health care information to complete treatment, billing and payment and health care operations already in progress. I agree to this when I signed the "Consent for Use and Disclosure of Health Care Information".
- Tri-City Orthopaedic Clinic, PSC is required in certain situations to release health care information with out my consent.
- Tri-City Orthopaedic Clinic, PSC does not have to provide any further health care services to me.

_____ _____

(Patient or legally authorized signature) Date

_____

Relationship to patient if signed by anyone other than the patient (parent, legal guardian, etc)

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