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**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)