Marshfield Clinic Health System

Clear Form

Patient Name:	MRN:	DOB:	Sex:

Release of Information Revocation Notice

Patient Information	Name		Date of Birth
	Address		Phone #
	City	State	ZIP

I hereby revoke the following authorization form:

Type of Form	☐ Release of Information Authorization ☐ Sharing of Information Authorization
Date the form was originally signed	Date: _____
Person or Organization listed on the form being revoked	Person/Organization: _____ Address _____ City/State/Zip:

I understand that this revocation of the release of information form listed above will not be valid where Marshfield Clinic Health System has already disclosed my personal health information in reliance upon my authorization.

_____ _____
Patient Signature Date/Time

_____
Printed name

_____ _____ _____
Signature of Authorized Person Date/Time (Relationship)

_____
Printed name

☐ Parent of Minor ☐ Court appointed guardian/conservator - include legal documentation

Mail Form to: MCHS, 1000 North Oak Avenue, Marshfield, WI 54449
ATTN: Health Information Management, HM2

Fax Form to: 715-389-0564
Email Form to: medicalrecords@marshfieldclinic.org

