reliance on the authorization I signed earlier. This revocation does not revoke any and all previous authorizations to release information that I have provided to Adventist Health.

Signature: _____ Date:_____Time: _____
(Patient/Legal Representative)

If signed by other than patient, indicate relationship:_____

Witness: _____

**********For Office Use Only**********

Medical Record Number: _____ Clerk's Initials: _____