ENDLESS NORTH CLINIC

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Revocation of Release of Information (ROI)

Patient Name _____ Date of Birth _____

Address _____

I hereby revoke my prior authorization dated: _____

This revocation applies to the release of my protected health information to:

Name/Organization: _____

Address and or Phone/Fax: _____

Revocation Details

I understand that this revocation:

- Does not affect any information already released before this revocation was received by Endless North Clinic.
- Remains in effect unless or until I sign a new release of information in the future.
- May not apply to disclosures required by law or made in reliance on the original authorization.

Reason for Revocation (Optional): _____

Parent/Guardian Full Name	Parent/Guardian Signature	Date

Relationship to patient (if applicable): _____

Minors (Age 16+) Full Name	Minors (Age 16+) Signature	Date

Provider Full Name	Provider Signature	Date

Office Use Only:

Received by: _____ Date: _____

Your privacy and confidentiality are our priority. For questions regarding this revocation, please contact our office at (763) 284-1877.