GRANT COUNTY FIRE PROTECTION DISTRICT NO. 3

Revocation of Authorization to Use or Disclose Health Information

Patient name:	Date of	birth:	
Previous name(s):			
Revoke my authorization, dated:			
Disclose no more information to:			
Name (or title) and organization:			
Address:			
I understand that this request does not a	pply to any uses	s or disclosures:	
 Before the District receives this revocati Allowed or required by law. 	on, or		
Patient or legally authorized individual sig	gnature	Date	Time
Printed name if signed on behalf of the p	atient Relations	ship (parent, legal g personal repre	
Appendix 01 02 07 Spure (Other Revocation)	Page 1 of 1	Revised 8/12/20203	. / /