



Board-Certified Orthopaedic Surgeons
Robert A. Kayal, MD, FAAOS
Edward C. Friedland, MD, FAAOS
Lori G. Weiser, MD, FAAOS

REVOCAION OF AUTHORIZATION TO RELEASE HEALTH INFORMATION

I previously signed the following Authorization to Use and Disclose Medical Information:

Original Authorization

DATE: _____
PURPOSE: _____
AUTHORIZED RECIPIENT: _____
DESCRIPTION OF INFORMATION: _____

I hereby revoke such Authorization effective immediately. I understand that the revocation may not be effective to the extent that medical information may already have been use or disclosed pursuant to and in reliance on my prior Authorization. I also understand that this revocation applies only to the information specifically described in the above-referenced document, and does not affect any other Authorization I have given.

PATIENT NAME PATIENT DOB PATIENT SS#

SIGNATURE OF PATIENT OR RESENTATIVE* DATE

* If signed by a Personal Representative, the following information must also be included:

NAME OF PERSONAL REPRESENTATIVE

DESCRIPTION OF THE PERSONAL REPRESENTATIVE’S AUTHORITY TO ACT ON BEHALF OF THE PATIENT