Lake Region HEALTHCARE

LAKE REGION HEALTHCARE
712 Cascade St S | Fergus Falls, MN 56537
218.736.8000

Authorization Revocation Statement

TO: _____

_____

_____

I revoke any and all authorizations for release of information and/or verbal release of information that I have signed to release and/or obtain to the facility/provider/person(s) listed below.

_____

(Name of Facility/Provider/Person being revoked)

_____

Date of Original Authorization for Release

_____

Print Patient Name and Date of Birth

_____

Patient Signature

_____

(Relationship if signed by person other than patient)

Date: _____