PATIENT REQUEST FOR REVOCATION OF RESTRICTION(S) ON HEALTH INFORMATION

Patient Name: _____ Date of Birth: _____

Patient Address: _____

Patient Telephone Number: _____

I hereby revoke the following restriction(s) except to the extent that TGH has already taken action in reliance thereon:_____

_____

_____

_____

_____

SIGNATURE OF PATIENT OR PERSONAL REPRESENTATIVE *(If Personal Representative, state relationship to patient)*	DATE
SIGNATURE OF WITNESS *(If signature of patient is a thumbprint or mark)*	DATE

Patient Information

Patient Request for Revocation of Restriction(s) on Health Information

Tampa General Hospital