4602 Cumberland Road
Fayetteville, NC 28306
Phone (910) 423-5622
Fax (910) 378-1755

RECOVATION OF RELEASE OF INFORMATION

I do hereby request that the authorization to exchange/disclose the health information of

_____, originally signed on _____,
Patient's Name *Date originally signed*

by _____, be rescinded, effective _____.
Name of original signer *Date authorization to end*

I understand that any action taken on this authorization prior to the rescinded date is legal and binding.

Signature of Parent/Guardian_____

Relationship_____

Date_____

Witness (if required)_____

Date_____