REVOCATION OF AUTHORIZATION TO RELEASE MEDICAL RECORDS

Patient Name:	Date of Birth:
Address:	Last 4 of SSN:
City, State, Zip:	Phone: ( )
E-mail:	

I revoke the Authorization to Release Medical Records that authorized Monarch to disclose protected health information to the following individual and/or organization:

Name of Individual:

Name of Organization:

Street Address or P.O. Box:

City, State, Zip:

Fax:

E-mail:

Date of Authorization:

I understand that this revocation: (1) will not affect any action taken before the receipt of this written revocation; and (2) will not affect any other authorization(s).

Signature of Patient/Representative:

Print Name:

Date:

Please return completed forms to Monarch's Medical Records Department: 350 Pee Dee Avenue, Suite 101, Albemarle, NC 28001; e-mail: medicalrecordsrequest@monarchnc.org (please note that unencrypted e-mail may not be secure); fax: (704) 786-1725; or drop them off at any Monarch location.