William M. Sergakis, D.D.S.
7240 S. Highland Drive Suite 102
Salt Lake City, UT 84121
(801)733-0864

NOTICE OF REVOCATION OF CONSENT TO USE AND DISCLOSE PROTECTED HEALTH INFORMATION

Patient Name: ____

This notice revokes the consent to use and disclosure of my protected health information that was originally signed on the _____day of ______________, 20____.

I understand that this revocation only applies to information collected on or after the date I have signed, and delivered this notice to you.

This revocation will in no way limit you in seeking payment for services that you provided under an earlier consent, or to meet legal obligations related to those services.

I understand that you have the right to refuse services to me as a result of this notice of revocation of protected health information for the purposes of treatment, payment, or health care operations.

This revocation is effective ____

Dated: ____________ day of ___________, 20___.

Patient Name: ____

Relationship to patient: ____

Signature: ____