

**CONSENT DIRECTIVE: REVOKING OF PATIENT
CONSENT TO LOCK PERSONAL HEALTH INFORMATION**

I, _____, wish to REVOKE my consent to lock my personal
(Print Full Patient Name)
health information.

This REINSTATEMENT of consent does not have a retroactive effect.

Patient Information: (please print)

Date of Birth: _____
(yyyy mm dd)

Mailing Address: _____

Telephone #: _____ Alternate #: _____

Signature: _____ Date: _____
(yyyy mm dd)

If you are a Substitute Decision-Maker (SDM), we require the following information:

Last Name: _____ First Name: _____ Middle Initial(s) _____

Mailing Address: _____

Telephone #: _____ Alternate #: _____

Signature: _____ Date: _____
(yyyy mm dd)

INTERNAL USE

DATE LOCK REMOVED: _____
(yyyy mm dd)

Lock Removed From: Entire Record ☐ Sequestered Visit(s) ☐ Process Excluded Employee ☐

COMMENTS:

Staff Signature: _____ **Staff Printed Name:** _____ **Date:** _____
yyyy/mm/dd