# HIPPA AUTHORIZATION FORM
# REVOCATION SECTION

I do hereby request that this authorization to disclose immunization information

of _____signed by _____
(Name of child) (Name of person signed Authorization)

on _____ be rescinded, effective_____.
(Date) (Date)

I understand that any action taken by the named providers or School in accordance to this authorization prior to the revocation date is legal and binding.

_____ _____
(Signature of Client/Patient) (Date)

_____ _____
(Signature of Personal Representative) (Date)

_____ _____
(Signature of Witness) (Date)