AMAZON CLINIC
WRITTEN NOTICE OF REVOCATION OF AUTHORIZATION TO USE AND DISCLOSE PROTECTED HEALTH INFORMATION

Individual's Name:	_____ First Middle Last
Home Address:	_____
	_____
Home Telephone:	_____
Date of Birth:	_____
Email:	_____

I hereby revoke the authorization agreed to by me on _____ **[insert date]**, a copy of which is located here.

I understand that this revocation will not be valid where **AMAZON CLINIC and its affiliates** (collectively, the "Company") has already acted in reliance upon my authorization.

_____ _____
Signature of Patient (or Personal Representative) Date

_____
Printed Name of Personal Representative

Relationship to Patient: _____

If you have any questions regarding this form, you may contact Amazon Clinic Customer Service by telephone at **855-682-2766**.

A copy of this Written Notice of Revocation shall be placed in your **Amazon Clinic** profile or the **Amazon Clinic** profile of the individual on whose behalf you have submitted this revocation.