**REVOCATION OF PERSONAL REPRESENTATIVE DESIGNATION FORM**

This personal representative designation applies to Behm Family Practice, LLC only

**REQUIRED INFORMATION**

|  |  |  |
| --- | --- | --- |
| Patient’s Name: | Patient’s Date of Birth: | Patient’s Phone: |
| Patient’s Address: |  |  |
|  |  |  |
| Personal Representative whose privileges are being revoked: |  | Personal Representative Phone: |
| Personal Representatives Address: |  | Personal Representative Fax: |

I verify that I no longer allow the above person to be provided with any information regarding my healthcare.

**REQUIRED SIGNATURE:**

**Patient’s signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_\_\_\_\_\_**