Confederated Tribes of Siletz Indians
Siletz Community Health Clinic
Post Office Box 320 • 200 Gwee-Shut RD
Siletz, OR 97380
Telephone: 800-648-0449 • (541)444-1030
Facsimile: (541)444-9695

Request for Revocation of restriction(s)

Complete and return this form to the above address to the attention HEALTH INFORMATION STAFF.

I hereby revoke the following restriction(s) except to the that SCHC has already taken action in reliance thereon:

Print name, sign and date. If your signature is your mark or thumbprint then your Representative or Witness will need to sign and state their relationship to you.

Print Patient's Name (First, Middle Initial and Last)	Date Signed
Signature of Patient	Mark or Thumb Print
Signature of Personal Representative or Witness	Relationship

SCHC is revoking the following restriction(s):

Signature of SCHC Administrator or Designee	*Date Signed*

SCHC HEALTH INFORMATION USE ONLY:

NAME (Last, First, MI)	MRN	DOB	Scanned