



CARY HEALTHCARE ASSOCIATES, PA  
301 ASHVILLE AVENUE, SUITE 1111 ◊ CARY, NC 27518  
919-233-6000 TEL ◊ 919-233-6052 FAX

## Authorization Revocation Form

I, \_\_\_\_\_, revoke the previously signed authorization consent form for:

- Compound Authorization for Release of Information
- Consent to Treat a Minor
- Consent to Treat a Minor (aged 16-18)

Signing below, I understand that Cary Healthcare Associates will no longer adhere to the provisions of the marked Authorization above which was originally completed on

\_\_\_\_\_  
(Original authorization date)

**\*\*To reinstate any of the above Authorizations a new form must be completed\*\***

\_\_\_\_\_  
(Printed name)

\_\_\_\_\_  
(Signature)

\_\_\_\_\_  
(Authorized Office Staff/Witness)

\_\_\_\_\_  
(Date of Revocation)