ALASKA NATIVE MEDICAL CENTER

REQUEST FOR REVOCATION OF RESTRICTION(S)

Patient Name	Date of Birth	Patient Record Number
Patient Address	City, State, Zip	Telephone # Alternate #

I hereby revoke the following restriction(s) except to the extent that ANMC has already taken action in reliance thereon.

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Signature of Patient or Legal Guardian/ Representative:	Date and Time:
For Organization Use Only:	
Date and Time Revocation of Restriction Received:	Date and Time of Revocation of Restriction Processed:
ANMC is revoking the following restriction (s):	
Name and Title of Staff Member Processing Request:	
Chart #:	Verification Method: