

REQUEST FOR REVOCATION OF RESTRICTION(S)

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

SIGNATURE OF PATIENT OR PERSONAL REPRESENTATIVE <i>(If Personal Representative, state relationship to patient)</i>	DATE
SIGNATURE OF WITNESS <i>(If signature of patient is a thumbprint or mark)</i>	DATE

IHS is revoking the following restriction(s):

SIGNATURE OF CHIEF EXECUTIVE OFFICER (CEO) OR DESIGNEE	DATE
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OMB BURDEN STATEMENT

Public reporting burden for this collection of information is estimated to average 10 minutes per response including time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. An agency may not conduct or sponsor, and a person is not required to respond to, a collection of information unless it displays a currently valid OMB control number. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden to: Information Collection Clearance Officer, Indian Health Service, Office of Management Services, Division of Regulatory Affairs, 5600 Fishers Lane, Mail Stop 09E70, Rockville, MD 20857, RE: OMB Control No. 0917-0030. Please DO NOT SEND this form to this address.

PATIENT IDENTIFICATION

	NAME <i>(Last, First, MI)</i>	RECORD NUMBER
	ADDRESS	
	CITY/STATE/ZIP	DATE OF BIRTH