

## 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

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0917-0030. The time required to complete this information collection is estimated to average less than 10 minutes per response, including the time to review instructions, search existing data resources, gather the data needed, to review and complete the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: Indian Health Service, OMS/DRPC, 5600 Fishers Lane, Rockville, MD 20857, Attention: Information Collections Clearance Officer.

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