



MyChart Proxy Revocation

Date_____

I, _____, hereby revoke MyChart Proxy authorization.
Patient Name

for, _____, effective immediately.

This includes, but is not limited to, access to receive verbal and/or written medical information on my behalf.

Please print and sign your name below:

_____	_____
Patient Name	Date of Birth
_____	_____
Patient Signature	Date/time
_____	_____
Employee Signature	Date/time

Please submit form to:

Riverwood Healthcare Center
ATTN: HIM Department
200 Bunker Hill Drive
Aitkin, MN 56431

Patient Identification