

OWYHEE COMMUNITY HEALTH FACILITY
Request for Revocation of Restriction(s)

I hereby revoke the following restriction(s) except to the extent that OCHF 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

OCHF is revoking the following restriction(s):

SIGNATURE OF THA OR DESIGNEE	DATE
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Patient Identification:

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