EMORY HEALTHCARE

Name: _____

Date of Birth: _____

USE THIS AREA FOR LABEL WITH PATIENT INFORMATION

Request to Revoke Clinical Research Authorization

I previously signed an authorization to:

- Allow Emory Healthcare to mark my medical record to indicate that I agree to be contacted about joining clinical research studies
- Allow Emory researchers to look at my medical record to see if I might be a match for one or more clinical research studies
- Allow Emory researchers to contact me about participating in clinical research studies

Now I have changed my mind and request to revoke ("cancel") my Clinical Research Authorization. Please update my medical record accordingly.

I understand that this revocation must be done in writing and be submitted to the Medical Records Department(s) of the Emory Healthcare facilities.

(NOTE: Processing this revocation will take up to 30 days)

SIGNATURE(S):

_____ _____

Signature of Patient Date
(or Patient's Legally Authorized Representative)

(If you are a Legally Authorized Representative, you need to **print** your name below and let us know why you are allowed to sign for the patient.)

_____

_____

Please Return this Authorization to:
Emory Clinic, Health Information Management Dept.
1550 Litton Drive
Stone Mountain, Georgia 30083