

**REQUEST FOR REVOCATION OF RESTRICTION(S)**  
45 CFR 164.522(a)

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) or Witness (if signature is thumbprint or mark)</i>	DATE
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IHS is revoking the following restriction(s):

SIGNATURE OF CEO OR DESIGNEE	DATE
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OMB 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: Indian Health Service, 801 Thompson Ave., TMP Suite 450, Rockville, MD 20852, RE: PRA 0917-0030. Please DO NOT SEND this form to this address.

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