DEPARTMENT OF HEALTH AND HUMAN SERVICES
Indian Health Service

REQUEST FOR REVOCATION OF RESTRICTION(S)

Form Approved: OMB No. 0910-0030
Expiration Date: December 31, 2026
See OMB Statement below.

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 *(If Personal Representative, state relationship to patient)*	DATE *(mm/dd/yyyy)*
SIGNATURE OF WITNESS *(If signature of patient is a thumbprint or mark)*	DATE *(mm/dd/yyyy)*

IHS is revoking the following restriction(s):

SIGNATURE OF CHIEF EXECUTIVE OFFICER OR DESIGNEE	DATE *(mm/dd/yyyy)*

OMB 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.

PATIENT IDENTIFICATION

NAME *(Last, First, MI)*	
ADDRESS	
CITY/STATE	
DATE OF BIRTH *(mm/dd/yyyy)*	RECORD NUMBER

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