Name of Client/Patient Date of Birth (mm/dd/yyyy) Phone Number

Address City, State, Zip

I revoke the authorization for the release of PHI to:

I understand that this revocation will not have any effect on Disclosures made prior to receipt of this revocation.

Signature: Date:

If this form is completed by a parent/guardian/authorized agent on behalf of the client/patient, complete the following:

Parent/Guardian/Authorized Agent’s Name (please print)

Please check one of the following:

[ ]  Parent/Guardian

[ ]  Authorized Agent

|  |
| --- |
| For Office Use Only If Records Requested to be Inspected:Name of Inspecting Person:       Records Released for Inspection:        |