

**REVOCATION OF AUTHORIZATION TO USE AND DISCLOSE INFORMATION**

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| **CLIENT INFORMATION** | |
| NAME: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  *Last First MI* | |
| ALIAS: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | |
| SSN: \_\_\_\_ - \_\_\_\_ - \_\_\_\_\_\_\_\_\_\_\_\_ | DOB: \_\_\_\_ / \_\_\_\_ / \_\_\_\_\_\_\_\_\_\_ |

*This form is to be completed when a client requests to revoke or cancel an existing authorization permitting Greater New Beginnings to release protected Health Information (PHI) to another person or organization. This form is to be completed only by the client or their authorized representative.*

This revocation request only applies to the individual(s) or organization(s) listed (INITIAL BELOW):

\_\_\_\_ I revoke ALL previous authorizations that I have signed.

\_\_\_\_ I revoke the authorization I signed on the following date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

releasing information to: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_ I request the authorization I signed on the following date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

releasing information to: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

be modified to revoke authorization to release the following specific protected health

information (list information that you DO NOT want released): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I understand that my written revocation will be effective upon receipt, but will not be effective to the extent that the requester or others have acted in reliance upon the authorization that I provided prior to this revocation.

I understand that revocation will not apply to information that has already been released and Greater New Beginnings shall continue to disclose PHI to third parties as required by law, which may include a disclosure(s) to the individual(s) or entity named in this revocation.

**TODAY’S DATE:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **SIGNATURE:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**PRINTED NAME:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**RELATIONSHIP (choose one):** € Client € Parent € Guardian € Representative € Conservator € Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**ADDRESS:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **TELEPHONE #:** ( ) -