

REVOCACTION SECTION

I do hereby request that this authorization to disclose health information of _____
(Name of Client)

signed by _____ on _____
(Enter Name of Person Who Signed Authorization) (Enter Date of Signature)

be rescinded, effective _____. I understand that any action taken on this authorization prior to the
(Date)

rescinded date is legal and binding.

(Signature of Client) (Date) (Signature of Witness) (Date)

(Signature of Personal Representative) (Date) (Personal Representative Relationship/Authority)

VERBAL REVOCATION SECTION

I do hereby attest to the verbal request for revocation of this authorization by _____
(Name of Client or Personal Representative)

on _____. The client or his personal representative has been informed that any action
(Date)

taken on this authorization prior to the rescinded date is legal and binding.

(Signature of Staff) (Date) (Signature of Witness) (Date)