Revocation of Consent to Release Information

I hereby revoke *(take back)* the previously executed authorization for:

_____ _____
Name of Individual/Patient Date of Birth

to use/disclose information to this individual/program/agency:

Name: _____

Organization: _____

Street Address: _____

City, State, Zip Code: _____

Phone: _____

I am aware the revocation of consent does not affect information disclosed while the authorization was in effect – and - providers who already have my information do not have to take it out of their records.

_____ _____ _____
SIGNATURE of Individual or Personal Representative Printed Name Individual Date

_____ _____
Printed Name of Personal Representative (if applicable) Description of Authority of Personal Representative (e.g. Parent/Guardian)

_____ _____ _____
SIGNATURE of Witness Printed Name of Witness/Title Date