v.JT23.4

COMPLETE NEUROPSYCHOLOGY SERVICES
CLIENT AUTHORIZATION REVOCATION

Full Legal Name: _____ Date of Birth: _____

Phone Number: _____ Email (optional): _____

Address: _____

City: _____ State: _____ ZIP: _____

To request revocation of any previously authorized release of my protected health information, I must complete this entire form OR notify Complete Neuropsychology Services in writing with a letter. The letter must be signed and include my full name, date of birth, phone number, and the forms (and dates) I am requesting to revoke. I understand that if the letter does not include all the required items listed, there could be a delay in processing my request, and my health information, and my health information could be released.

Please note: A revocation request is not a request to restrict disclosure of your protected health information (PHI) You have a right to request restriction under HIPAA. Complete Neuropsychology Services does not agree to restrictions that could impede a client's treatment or that cannot reasonably be implemented.

This form must be either mailed or faxed to:
Complete Neuropsychology Services, 1056 Charles Orndorf Dr., Suite G, Brighton, MI 48116 or fax (734) 480-8870.

I request confirmation of this request sent to me by: ☐ Phone Call ☐ Text ☐ Email ☐ US mail

I am requesting the revocation of the following previously submitted authorizations (Please include the date I signed the form I now seek to revoke.):

☐ **RELEASE OF INFORMATION AUTHORIZATION:**

Individual/Entity: _____ Signature date: _____

☐ **RELEASE OF INFORMATION AUTHORIZATION:**

Individual/Entity: _____ Signature date: _____

☐ **Other Form:** _____:
(name)

Individual/Entity: _____ Signature date: _____

_____ _____ _____
Signature of Individual (the person about whom the information relates) OR, if applicable sign below | Date of Individual's Signature | Date of Birth

_____ _____ _____
Signature of Guardian or Personal Representative of the Patient's Estate | Date of Guardian's/Personal | Description of Authority to Act