Max Psychiatry

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REVOCATION OF AUTHORIZATION TO DISCLOSE HEALTH INFORMATION

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be rescinded, effective _________________.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rescinded date is legal and binding.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taken on this authorization prior to the rescinded date is legal and binding.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)*