Revocation of Consent to Release Information

Client Name:	Phone:
Client Date of Birth:	

I hereby revoke any previous authorization to disclose my protected health information for the following individual or entity:

____
Name of Entity/Individual

I understand that by signing below, this written statement revokes the previous authorization to disclose my protected information.

I understand that no revocation of this consent shall be effective to prevent disclosure of records and/or communications until it is received by the person otherwise authorized to disclose records and communications.

I further understand that the revocation will only apply to further disclosures or actions regarding my personal health information and cannot cancel actions or disclosures made while the disclosure was previously in effect and valid.

______________________ Signature of Client	______________________ Signature of Client's Legal Representative
______________________ Date	______________________ Legal Representative's Relationship to Client

Revocation of consent to release information may be made in writing to:
38882 Mentor Ave, Willoughby, OH 44094, Attn: HIPAA Privacy Officer.