# Revocation of Consent for Use and Disclosure of Health Care Information

Client name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of birth: \_\_\_\_\_\_\_\_\_\_\_\_

SSN: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Previous name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I no longer want (clinician) to use and disclose health care information about me for treatment, billing and payment, and health care operations.

I understand that:

* This request applies after I sign this document.
* (Clinician) may have already taken action based upon my earlier permission.
* (Clinician) is allowed, by law, to use and disclose my health care information to complete treatment, billing and payment, and health care operations already in progress. I agreed to this when I signed the “Consent for Use and Disclosure of Health Care Information.”
* (Clinician) is allowed or required by law to release health care information without my permission under certain situations.
* (Clinician) does not have to provide any further health care services to me.

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Client or legally authorized individual signature Date Time

Relationship to patient if signed on behalf of the patient by parent, legal guardian, personal representative, etc.:

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Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_