mindful therapy group

REVOCATION OF AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

Instructions: This form must be completed to revoke a previously authorized Release of Health Information. This revocation will not influence any actions taken prior to the date this document is received and processed, nor future disclosures to the extent that action was already taken based on the previous authorization.

This form must be completed and signed by the client or authorized representative who previously authorized the release of health information.

Patient Name: _____

Date of Birth: _____/_____/_____

Request Date: _____/_____/_____

I revoke the below Authorization for Release of Health Information:

Date of Authorization: _____/_____/_____

Individual/Entity: _____

I have had the opportunity to read this Revocation of Authorization and understand it will take effect once Mindful Therapy Group has sent written confirmation that it has been received and processed.

Signatory Name: _____

Signature of Patient or Authorized Representative: _____

Date: _____/_____/_____

Relationship if not Patient: _____