WHITMAN COUNTY LEOFF I BOARD
400 N Main Street, Colfax, WA 99111
(509) 397-5246
FAX (509) 397-6355

REVOCATION OF AUTHORIZATION FOR USE OR DISCLOSURE OF HEALTH CARE INFORMATION

Client's Name:_____

Previous Name:_____

_____ (**Initial**) Please revoke my authorization dated:_____

Disclose no further information to:_____

_____

Address:_____

_____

I understand that this request does not apply to any uses or disclosures required by law and/or made before this revocation is received by the appropriate organization.

_____ _____

Client or Legal Authorized Individual Signature Date

_____ _____

Printed Name if Signed on Behalf of the Client Relationship to Client

WCLIB #18