



REVOCATION OF AUTHORIZATION FOR USE OR DISCLOSURE OF HEALTH CARE INFORMATION

400 N. Main Street • Colfax, WA 99111 • (509) 397-5240 • FAX (509) 397-6355

Client's Name: _____

Previous Name (if applicable): _____

_____ **(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 Legally Authorized Individual Signature

Date

Printed Name if Signed on Behalf of the Client

Relationship to Client