REVOCATION OF AUTHORIZATION
FOR DISCLOSURE OF HEALTH INFORMATION

ADMINISTRATION OFFICE
4110 Briargate Parkway, Suite 300
Colorado Springs, CO 80920
(719) 632-7669

PLEASE PRINT

I do hereby request that this authorization to disclose health information of____________________
Name of Patient

Signed by____________________ on ____________________
Name of Person Who Signed Authorization | Date of Signature

be rescinded, effective ____________________.
Date

I understand that any action taken on this authorization prior to the rescinded date is legal and binding.

____________________	__________	____________________	__________
Signature of Patient	Date	Signature of Witness	Date
____________________	__________	____________________	
Signature of Personal Representative	Date	Personal Representative Relationship/Authority	

VERBAL REVOCATION SECTION

I do hereby attest to the verbal request for revocation of this authorization by ____________________
Name of Patient or Personal Representative

on ____________________. The client or his personal representative has been informed that any action taken on this
Date

authorization prior to the rescinded date is legal and binding.

____________________	__________	____________________	__________
Signature of Staff	Date	Signature of Witness	Date