REVOCATION OF AUTHORIZATION TO RELEASE INFORMATION

I, _____ (*print name)*, DOB _____, hereby revoke the Authorization to Release Information previously signed by me which authorized my provider, Amy Craig-Van Grack, LCSW-C and/or administrative staff of BPC&C to release, obtain, or exchange information from my clinical record to another person/entity.

Please initial the statement below which applies to this Revocation:

_____This Revocation applies to all Authorizations signed by me for this provider.

_____This Revocation applies only to a specific Authorization signed by me for this provider. All other Authorizations remain in effect until they expire by default or by a separate Revocation.

Person/Entity:_____
Date of Authorization:_____

I understand that this Revocation is not retroactive; it applies from the date the signed Revocation was received by my provider as indicated below.

I understand that my provider may already have taken action based upon my prior Authorization.

I understand that my provider 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. This Revocation will not be effective if an Authorization was obtained as a condition of procuring insurance payment for services rendered and the provider or the insurer has a legal right to contest a claim.

I understand that my provider is allowed or required by law to release health care information without my permission under certain limited circumstances.

I understand that, if provider is continuing to provide services to me, I may be required to sign a new Authorization to Release Information in the future.

_____ _____
Signature of Client or Parent/Guardian Date

_____ _____
Print Name Relationship to Client

_____ _____
Print Client's Name Client's DOB

Date of Receipt by Provider: Signature of Provider:

_____ _____