REVOKE OF AUTHORIZATION - INDIVIDUAL

You have the right to revoke a valid authorization to disclose information at any time. By completing this form you are requesting a restriction to any further disclosures of your personal health information to that entity.

To do so, you must fill out this form and return it to NWMHC *(accepted in person or via jotform).*

CLIENT INFORMATION
Date of Birth: ________________

Legal Name:
First Name ____________________________ Last Name ____________________

Preferred Name:
First Name ____________________________ Last Name ____________________

I wish to revoke my authorization for RELEASE of protected health information from NWMHC to the following individual:

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Please know, this is individual specific

This revocation is given freely and with the understanding that:

- Disclosures made in good faith may have already occurred based on my previously issued authorization and that this revocation cannot apply retroactively to such disclosures.
- Records already released by the valid authorization cannot be retracted.
- I understand that the disclosure of health information may be required by law in certain limited instances despite this revocation.
- I understand that no revocation of this consent shall be effective to prevent disclosure of records and/or communications until it is received by the person otherwise authorized to disclose records and communications.
- I further understand that the revocation will only apply to further disclosures or actions regarding my personal health information and cannot cancel actions or disclosures made while the disclosure was previously in effect and valid.
- The facility and its employees are hereby released from any legal responsibility or liability for disclosure of the information I previously authorized.

ATTENTION: This is a legal document. Please read carefully.
By signing, you agree that you understand and accept the terms in this form.

- ☐ If the client is 18 years of age or older, the client must sign and date the form.
- ☐ If the client is 18 years of age or older and is incapable of signing, a legally authorized substitute may sign and date the form.
- ☐ If the client is 17 years of age or younger, the client's parent or legal guardian must sign and date the form, unless an exception exists under state or federal law.

Please select one:

- ☐ **I am 18 years of age or older and will be signing this form**
- ☐ **Client is 18 years of age or older and is incapable of signing**
- ☐ **Client is 17 years of age or younger**
- ☐ **I am 17 years of age or younger, but can sign due to a legal exception**

Print Name of Authorized Signee: ____

- ☐ Self
- ☐ Parent
- ☐ Legal Guardian
- ☐ Conservator Health Care Agent/Health Care Power of Attorney

Signature:

____

My signature indicates that I am legally authorized to sign

Date: ______________________