

REVOCATION OF AUTHORIZATION

TO USE OR DISCLOSE PROTECTED HEALTH INFORMATION (PHI)

PHOTOCOPY/FACSIMILE COPY MAY BE USED AS AN ORIGINAL

CLIENT(PATIENT) INFORMATION:

NAME: Last First MI

AKA:

SOC. SEC.#: - - DATE OF BIRTH: / /

I hereby REVOKE the authorization to use or disclose the named individual's Protected Health Information as described here.

Individual or organization originally authorized TO USE OR DISCLOSE PHI: Complete Address: Street Address City State Zip

Individual or organization originally authorized TO RECEIVE the information: Complete Address: Street Address City State Zip

MEDICAL RECORDS/PHI (California Civil Code 56.10, TITLE 17, Health and Safety Code 120175) AND OTHER INFORMATION

PSYCHIATRIC/MENTAL HEALTH/INCLUDING PSYCHOTHERAPY NOTES PHI (CAL W&I Code Section 5328)

ALCOHOL/SUBSTANCE ABUSE TREATMENT PHI (Section 42 Part 2 Code of Federal Regulations)

HIV RESULTS/AIDS TREATMENT PHI (Health and Safety Code 120980)

Limits of Revocation: I understand that this revocation will not apply to information that has already been released based on the authorization I signed on:

TODAY'S DATE: SIGNATURE:

PRINTED NAME:

RELATIONSHIP: Choose One: Client(Patient) Parent Guardian Representative Conservator Other:

COMPLETE ADDRESS: Street Address City State Zip Code TELEPHONE # () -

Please return this completed form for processing to the Custodian of Records office at 200 W. Santa Ana Blvd, Ste 125, PO Box 355, Santa Ana, CA 92702 Phone (714) 834-3536; Fax (714) 835-9312