REVOCATION OF AUTHORIZATION
TO RELEASE PROTECTED HEALTH INFORMATION

I, _____, hereby revoke the authorization to release information I or my personal representative completed and signed on (date) _____ that permitted Highlands Behavioral Health Systems to use and disclose my protected health information as designated on said authorization form to obtain information from or release information to (facility/person) _____.

I understand that this revocation does not apply to any action Highlands Behavioral Health Systems has taken in reliance on the authorization I had signed.

This authorization does not revoke any and all previous authorizations to release information that I have provided to Highlands Behavioral Health Systems.

_____ _____
Patient Name Medical Record

_____ _____
Patient/Patient Representative Signature Date

_____ _____
Witness Date

SPECIAL PROVISIONS

List and detail any special provisions regarding the revocation of the authorization to release information

_____

_____

_____ _____
Patient/Patient Representative Signature Date