Clifford Beers Clinic
REVOCATION OF PERMISSION TO SHARE INFORMATION

Client Name: _____

Date of Birth: _____

I hereby revoke the permission to share information pertaining to the client named above effective

_____.
(Today's Date)

Disclose no more information to:

Agency | Contact Person

Street Address | City

State | Zip Code | Phone Number

Disclose no more information to:

By checking this box I am revoking **ALL** releases of information on file for the Clifford Beers Clinic: ☐

Acknowledgements

I understand that this request does not apply to any uses or disclosures:

- Before the Clifford Beers Clinic receives this revocation
- Allowed or required by law

Signatures By signing below, I revoke the permission for the Protected Health Information to be shared.

Signature of Client **Date**

Guardian/Conservator's Printed Name

Signature of Guardian/Conservator **Date**

Staff Signature **Date**

Note: This form must be filled out by the person who originally granted consent, or the person named on the form once they have turned 18 or provided appropriate emancipation documents.

Revised 06/10/2019