VALLEY | CITIES
Behavioral Health Care

REVOCATION OF RELEASE OF INFORMATION

Client Name: _____ DOB: _____

I hereby revoke my prior Release of Information authorization to the following:

_____
Name of Organization/ Individual

_____
Street Address

_____
City State Zip Code

I understand this request does not apply to any use or disclosure:

- Before the Valley Cities Behavioral Health Care receives this revocation.
- As allowed or required by law.

This revocation will apply to **ANY ACTIVE** Release of information previously completed for the Individual/ Organization named above and becomes effective when processed by Valley Cities.

Signature:

Client/ Legal Authority Signature: _____ **Date:** _____

Written Name of Client/Legal Authority: _____

If the authorization is signed by a Legal Authority of the individual, a description of such representative's authority to act for the individual must also be provided.

Relationship to Client: _____

Description of Legal Authority: _____