Benson
psychological services

REVOCATION OF AUTHORIZATION TO DISCLOSE HEALTH INFORMATION

You have the right to revoke a previous 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.

I,_____
_____

(Print your name, date of birth, address and phone number)

hereby revoke any previous authorizations to disclose my protected health information to:

_____
_____

(Print the person or organization that you are revoking authorizations to)

I understand that by signing below, I revoke any previous authorizations to disclose my protected information. I understand that this request does not apply to any uses or disclosures:

- Before the practice/health care facility gets this revocation,
or
- Allowed or required by law.

Benson Psychological Services, PC will send a copy of this revocation to the above named entity informing them that the previous release of information has been revoked, unless you indicate by checking the box below that you do not wish for us to do so, or unless otherwise allowed or required by law

☐ I do not wish for the above named entity to be informed of this revocation

Printed Name: _____

Signature: _____

Date: _____