

WHITMAN COUNTY LEOFF I BOARD
400 N Main Street, Colfax, WA 99111
(509) 397-5246
FAX (509) 397-2099

REVOCAION OF AUTHORIZATION FOR USE OR DISCLOSURE OF HEALTH CARE INFORMATION

Client's Name: _____

Previous Name: _____

_____ (**Initial**) Please revoke my authorization dated: _____

Disclose no further information to: _____

Address: _____

I understand that this request does not apply to any uses or disclosures required by law and/or made before this revocation is received by the appropriate organization.

Client or Legal Authorized Individual Signature

Date

Printed Name if Signed on Behalf of the Client

Relationship to Client