ATTACHMENT G

Revocation of Authorization for Release of Protected Health Information (PHI)

I hereby revoke my prior authorization, which allowed _____
Name of hospital, agency, individual or class of individuals
to release or exchange records or protected health information obtained in the course of the diagnosis and treatment of:

_____, _____, _____
Full name of Individual-Served, including AKAs | *Date of Birth* | *Social Security #*

for mental health purposes and/or conditions related to alcohol and/or substance abuse to:

_____
Name of hospital, agency, individual or class of individuals

_____ _____
Address | *Phone number*

Initial

_____ I understand that Kern County Mental Health System of Care cannot be held liable for records and information released prior to this Revocation of Authorization for Release of Protected Health Information.

_____ A clinical team member has discussed with me the possible consequence of revoking this Authorization for Release of Protected Health Information.

_____ I have received a copy of this Revocation of Authorization for Release of Protected Health Information.

_____ _____
Signature of Individual-Served | Date

_____ _____
Parent/Legal Guardian Signature | Date

_____ _____
Staff Signature | Date