

# SHEPHERD'S STAFF CHRISTIAN COUNSELING CENTER

## **Revocation of Authorization for SSCCC to Use or Disclose Health Care Information**

Client name: \_\_\_\_\_ Date of birth: \_\_\_\_\_

Previous name: \_\_\_\_\_

**Revoke my authorization, dated:** \_\_\_\_\_

**Disclose no more information to:**

Name (or title) and organization: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

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

- Before SSCCC gets this revocation, or
- Allowed or required by law.

\_\_\_\_\_  
Client or legally authorized individual signature

\_\_\_\_\_  
Date signed

\_\_\_\_\_  
Printed name if signed on behalf of the client

\_\_\_\_\_  
Relationship (parent, legal guardian, personal representative)

Received by:

Date received:

\_\_\_\_\_  
(Signature of SSCCC staff member receiving this revocation)

\_\_\_\_\_