The Steven A. Cohen Military Family Clinic at Valley Cities

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 Cohen Clinic at Valley Cities 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: _____