SYNERGISM COUNSELING

Letter of Revocation for Authorized Protected Health Information (PHI)

I, _____, would like to revoke the authorization for _____ to receive records and or information concerning my care at Synergism Counseling. This revocation includes both written and verbal communication. I understand that any action taken on this authorization prior to the revocation date was done with my consent.

or

I, _____, the parent, legal guardian or representative of _____ would like to revoke the authorization for _____ to receive records and or information concerning my care at Synergism Counseling. This revocation includes both written and verbal communication. I understand that any action taken on this authorization prior to the revocation date was done with my consent.

I understand that if I am court ordered, the courts will be notified of this revocation and this can affect my standing with court(s).

This revocation is effective immediately. I understand that I may request a copy of this signed revocation.

Comments:

_____

_____

Signature:

_____ Date of Signature: _____
Client, Parent, Guardian or Legal Representative

Printed Name: _____

Client Date of Birth or Social Security Number _____