Community Mental Health Affiliates, Inc.

Revocation Form

. This form should be used when a client is revoking an authorization they have on file. If the client is revoking more than one authorization, a form must be completed for each revocation. Once the client or legal representative signs this form it must be submitted immediately to Medical Records, do not include the authorization. If the revocation is for a release signed with another agency, please indicate this on the form. Please contact Medical Records immediately when a client wants to revoke an authorization, this is time sensitive and needs to be noted in the record prior to submitting the form. Please contact Medical Records with any questions.

Medical Records Contact Info

Direct Line: 860-348-2310

Fax Line: 860-827-3473

Email: mrecords@cmhacc.org

CMHA
Community Mental Health Affiliates
233 Main Street | New Britain, CT 06051 | P 860.348.2310 | F 860.827.3473

Revocation of
Authorization to Release and/or Obtain Protected Health Information

Client Name:_____DOB:_____Epic MR#_____

I,_____
(Patient name or personal representative & relationship, if applicable)

wish to revoke the following authorization to release and/or obtain protected health information from my records held by Community Mental Health Affiliates, Inc. for the following Organization or Person:

_____ _____
Name of Organization or Person Authorization Date

I understand that by revoking the authorization it will not affect actions that CMHA took in reliance on the authorization while it was in effect.

_____
Print Name

_____ _____
Client or Legal Representative's Signature Date

If signed by the Legal Representative, indicate your relationship to the client below:

☐ Parent ☐ Guardian ☐ Conservator ☐Health Care Representative ☐ Executor of Estate
☐ Next of Kin ☐ Power of Attorney