



MR Number _____

Patient Name: _____

**REVOCATION OF AUTHORIZATION TO RELEASE INFORMATION
 FROM THE PATIENT RECORD**

PATIENT NAME	DATE OF ADMISSION	BIRTHDATE	SOCIAL SECURITY NUMBER

I do hereby REVOKE MY AUTHORIZATION to Conifer Park, Inc. to obtain from and release to:

NAME OF ORGANIZATION		NAME OF PERSON AND/ OR POSITION
STREET ADDRESS, INCLUDING APARTMENT OR SUITE NO. IF APPLICABLE		
CITY, STATE AND ZIP CODE		
PHONE NUMBER, INCLUDING AREA CODE	FAX NUMBER INCLUDING AREA CODE	E-MAIL ADDRESS

From this point forward, unless I reauthorize communication in writing, Conifer Park clinical, medical, administrative, and clerical personnel to MAY NOT exchange information about me.

I understand that my alcohol and drug treatment records are protected under the federal regulations governing Confidentiality of Alcohol and Drug Abuse Patient records and cannot be disclosed without my written consent unless otherwise provided for in the regulations. I also understand that records concerning mental health services are protected under state law.

I have received a copy of this revocation. I have waived my right to receive a copy of this revocation.

Patient Signature	Date
Parent or Legal Guardian Signature	Date
Legal Representative Signature	Date
Witness Signature	Date

AM-66 04/03

This information has been disclosed to you from records protected by Federal confidentiality rules (42 CFR Part 2). The Federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR Part 2. A general authorization for release of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient. Additionally, these records are protected by 45 CFR Parts 160 and 164 (HIPAA).