Letter of Revocation

HIM DEPARTMENT
MEDICAL RECORDS

4460 S. Highland Dr.
Suite 320
Salt Lake City, Utah 84124
801-273-6425
Fax 801-424-4043

I, _____, would like to revoke the authorization for _____ to receive records and or information concerning my care at Valley Behavioral Health. 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 Valley Behavioral Health. 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: _____

_____

Client , Parent, Guardian or Legal Representative Printed Name	Client Date of Birth or Social Security Number
Client , Parent, Guardian or Legal Representative Signature	Date of Signature