COMMONWEALTH OF MASSACHUSETTS
DEPARTMENT OF MENTAL HEALTH

Authorization Revocation

Name: Other Name(s):

Address: Phone:

Social Security #: Date of Birth:

I hereby revoke the Authorization for Release of Information that was given by me or my Personal Representative on _____(date), for_____ _____ and _____ to share Protected Health Information.

I understand that this revocation will not apply to information that has already been released. I understand that the revocation will not apply to my insurance company or other third party payer when the law provides my insurer or other third party payer with the right to contest a claim.

_____ _____
Your signature or Personal Representative's signature Date

_____
Print name of signer

THE FOLLOWING INFORMATION IS NEEDED IF SIGNED BY A PERSONAL REPRESENTATIVE

Type of authority (e.g., court appointed, custodial parent):_____

COPY OF THIS FORM SHOULD BE GIVEN TO DMH AND THE OTHER PERSON/FACILITY/AGENCY ORIGINALLY AUTHORIZED TO RELEASE OR RECEIVE THE PROTECTED HEALTH INFORMATION.