Full Name: ___________________________________

Date of Birth: _________________________________

Phone Number: _______________________________

**Revocation of Authorization to Release Information**

I, ______________________________________, hereby revoke the authorization signed by me on,

______________________, and submitted to DuPage County Health Department allowing the DuPage

County Health Department to release/share healthcare information with:

___________________________________________.
Organization/Provider/Person

I understand that this request does not apply to any disclosures:

- Already made when the release of information was in place;
- Made for the purposes allowed by HIPAA (Health Insurance Portability and Accountability Act) and the Illinois Mental Health Developmental Disabilities Confidentiality Act; or
- Made as required by law.

________________ ______________________________________
Date and Time Signature of Client

________________ ______________________________________
Date and Time Guardian Signature

________________ ______________________________________
Date and Time Witness Signature

Date Processed by Medical Records: ____________________

June 2017