REVOCATION of CLIENT AUTHORIZATION to RELEASE OF HEALTH INFORMATION

In accordance with RCW 70.02.040 and the HIPAA Privacy Rule, you have the right to revoke any Authorization for Release of Health Information:

> *A client may revoke in writing a disclosure authorization to a health care provider at any time unless disclosure is required to effectuate payments for health care that has been provided or other substantial action has been taken in reliance on the authorization. A patient may not maintain an action against the health care provider for disclosures made in good-faith reliance on an authorization if the health care provider had no actual notice of the revocation of the authorization.*

To do so, you must fill out this form and return/mail it to Cardona Counseling Services.
This revocation is given freely and with the understanding that:

- *Disclosures made in good faith may have already occurred based on my previously issued authorization and that this revocation cannot apply retroactively to such disclosures.*
- *I understand that the disclosure of health information may be required by law in certain limited instances despite this revocation.*
- *The revocation becomes effective once it is received by Cardona Counseling Services personnel.*
- *Records already released by the valid authorization cannot be retracted.*
- *The facility, its employees, officers, and physicians are associates released from any legal responsibility or liability for disclosure of the information I previously authorized.*

Individual Revoking the Authorization
Client Name: _____
Date of Birth: _____
Phone Number: _____
Address: _____
_____
DOC# (if applicable): _____

I hereby revoke the authorization I previously provided on (date) ____/_____/_____ that allowed Cardona Counseling to disclose to personal health information to:
_____(facility/person).

If signed by person other than the Client, state the relationship and authority to do so.

Client is: ☐ Minor ☐ Legally Incompetent or Incapacitated ☐ Deceased

Legal Authority: ☐ Legal Guardian ☐ Parent ☐ Executor of Deceased/Next of Kin

☐ Activated Power of Attorney for Healthcare or Other Legal Representative of patient (specify):_____

Note: It is the client's responsibility to inform the previously authorized requester of information that the Authorization has been revoked.

Mail to:
Cardona Counseling Services
Attn: Release of Information Dept
4500 9th Ave NE
Suite 300
Seattle, WA 98105

If you require evidence of sending an item, you can secure a Certificate Of Mailing, an official USPS record solely showing the date your mail was accepted.

(For Internal Use Only) Received By:_____ Date:_____
ROI:(Date)_____ (If received by a Clinic Site)Revoked
By:_____Date:_____Release Restriction Applied