Revocation of Authorization for Use and Disclosure of Protected Health Information

Name (*print first name, middle initial and last name*):	Date of Birth (*month/day/year*):

This notice revokes the authorization to the use and disclosure of Protected Health Information between:

Behavioral Health and Recovery Services Department of Health and Human Services

AND

Name of Agency, Individual, or Health Care Provider:		
Address:	**City/State:**	**Zip Code:**

Fax, mail, or hand deliver this form along with a photo ID to:

Behavioral Health and Recovery Services – County of Marin	
Department of Health and Human Services	Telephone: (415) 473-6835
250 Bon Air Road, Unit B, Greenbrae, CA 94904	Fax: (415) 473-4113
Contact: Custodian of Medical Records	

EFFECTIVE DATE:

The notice will be in effect when received by the County. Any information already shared by this authorization cannot be retracted.

EFFECTS OF REVOCATION: This revocation will not limit the ability for the Marin County Mental Health and Substance Use Services to seek payment for services it may have provided under this authorization.

EXPIRATION: This revocation will remain in effect until otherwise requested by the client in writing.

Signature (*Client or Representative, as appropriate*)*:	**Date** (*month/day/year*):
* *If form is signed by someone other than the client, state the relationship to client, and include required documentation of authority with the signed Authorization form.* Name (*print*): ____________________ Relationship:	
Name of County Representative Who Receives this Form:	**Date** (*month/day/year*):