WITHDRAWAL OF CONSENT FOR RELEASE OF INFORMATION

PATIENT’S LAST NAME  FIRST  M.I.  
CASE NO.  
FACILITY  UNIT  

INSTRUCTIONS: GIVE A COPY OF THE FORM TO THE PATIENT! Prepare one (1) copy for the Patient’s Case Record.

DISCLOSURE WITH PATIENT’S CONSENT

NAME OR TITLE OF PERSON OR ORGANIZATION TO WHICH THE DISCLOSURE WAS AUTHORIZED

TO:

NAME OR TITLE OF PERSON OR ORGANIZATION DISCLOSING INFORMATION

FROM:

DATE OF ORIGINAL AUTHORIZATION

I, the undersigned, hereby withdraw my authorization to disclose information to the above named individual/organization except to the extent that action has already been taken in reliance upon it.

I understand that generally the program may not condition my treatment on whether I agree to sign a consent form, but that in certain limited circumstances I may be denied treatment if I do not sign/or withdraw a consent form. I also recognize that there may be consequences if I withdraw a consent to disclose to a legal authority that requires such consent as a condition or release, probation, or parole. I have received a copy of this form, as recognized by my signature below.

___________________________________________________________  ___________________________________________________________
(Signature of Patient)  (Signature of Parent/Guardian, when required)

___________________________________________________________  ___________________________________________________________
(Print Name of Patient)  (Print Name of Parent/Guardian)

___________________________________________________________  ___________________________________________________________
(Date)  (Date)

(TRS-2.2)