MR Number_____   Patient Name:_____

REVOCATION OF AUTHORIZATION TO RELEASE INFORMATION FROM THE PATIENT RECORD

PATIENT NAME	**DATE OF ADMISSION**	**BIRTHDATE**	**SOCIAL SECURITY NUMBER**

I do hereby REVOKE MY AUTHORIZATION to Arms Acres, Inc. to obtain from and release to:

NAME OF ORGANIZATION	*NAME OF PERSON AND/ OR POSITION*
STREET ADDRESS, INCLULDING APARTMENT OR SUITE NO. IF APPLICABLE	
CITY, STATE AND ZIP CODE	

PHONE NUMBER, INCLUDING AREA CODE	*FAX NUMBER INCLUDING AREA CODE*	*E-MAIL ADDRESS*

From this point forward, unless I reauthorize communication in writing, Arms Acres clinical, medical, administrative, and clerical personnel to MAY NOT exchange information about me.

I understand that my alcohol and drug treatment records are protected under the federal regulations governing Confidentiality of Alcohol and Drug Abuse Patient records and cannot be disclosed without my written consent unless otherwise provided for in the regulations. I also understand that records concerning mental health services are protected under state law.

☐ I have received a copy of this revocation.   ☐ I have waived my right to receive a copy of this revocation.

Specify date, event, or condition upon which authorization expires sooner than 120 days from signing	
Patient Signature	**Date**
Parent or Legal Guardian Signature	**Date**
Legal Representative Signature	**Date**
Witness Signature	**Date**

04/11/03