SAGE
RECOVERY & WELLNESS CENTER

REVOCATION OF AUTHORIZATION TO RELEASE PRIVELAGED INFORMATION

As of _____, I, _____, hereby revoke any previous
(today's date) (print your name)

authorizations to disclose my privileged information to _____.
(organization or individual's name)

I understand that by signing below, revokes previous authorizations to release my privileged and protected information, and reinstates the privilege of confidentiality afforded for medical and mental health care.

I understand that no revocation of this consent shall be effective to prevent disclosure of records and/or communications until it is received by the Sage Recovery & Wellness Center staff who were otherwise authorized to disclose records and communications.

I further understand that this revocation will only apply to further disclosures or actions regarding my personal health information, and cannot cancel actions or disclosures made while the disclosure was previously in effect and valid.

A duplicate, photocopy or facsimile reproduction of this document may be used in lieu of the original.

_____ _____

Client Signature (legal guardian if patient is under 18) **Date**

_____ _____

Signature of Witness **Date**