Written Notice of Revocation of
an
Authorization to Use or Disclose Protected Health Information

Client Name: ____
Last First Middle

Date of Birth _____/______/____________

I revoke the Authorization created by me

On: ______/______/__________ [date]

For: ____ (individual and/or entity)

I understand that this Revocation will not be valid where LifeStance has already acted in response to the original Authorization.

You may file this Revocation in either of two ways:

1. Give the completed form to your therapist or the front desk at the clinic where you receive services.
2. Mail the completed form to Medical Records PO Box 82819 Portland, OR 97282

_______________________________________ _______________
Signature of Client (or Guardian) Date

If Parent/Guardian, print name: ____________________________

For Office Use Received: ______/______/__________
Scan into chart, Title with "Revoked" and then list the individual and/or entity and the date of this form