Coos Health & Wellness
Behavioral Health
1975 McPherson, Suite 2
North Bend, OR 97459

COOS COUNTY BEHAVIORAL HEALTH DEPARTMENT
NOTICE OF REVOCATION FOR RELEASE OF INFORMATION

Client's Name: _____
Last First Middle

Home Address: _____

_____

Home Telephone: _____ Date of Birth: _____

I understand that Coos County Behavioral Health Department has informed me that my health information, including information about mental health treatment may be used or disclosed for those purposes permitted by law for treatment, payment, and health operations.

I understand that I have also authorized the disclosure of my health information for purposes other than treatment, payment, and health operations as allowed under state and federal privacy laws.

By my signature below, I hereby **revoke the authorization** that I have previously signed for the following person(s):

RECIPIENT
NAME: _____

ADDRESS: _____

I understand that this revocation will be effective immediately upon Coos County Behavioral Health Department's receipt of my written notice, except that the revocation will not have any effect on any action taken by Coos County in reliance on the Authorization before it received this written notice.

_____ _____, _____
Signature of Client (or Personal Representative) Date of Signature

_____ _____
Printed Name of Personal Representative Relationship to Client