ARKANSAS DEPARTMENT OF HUMAN SERVICES

AUTHORIZATION TO DISCLOSE HEALTH INFORMATION

REVOCATION SECTION

<u>COMPLETE ONLY</u> WHEN REVOKING THE AUTHORIZATON

I do hereby request that this authorization to disclose health information of ______________________________
(Name of Client)

to ____ on ___________________________
(*Enter Name of Organization or Individual who will no longer have access to child records/information*) *(Enter Date of Signature)*

be rescinded effective __________________ I understand that any action taken on this authorization prior to the
(Date)

Rescinded date is legal and binding.

(Signature of Client)	*(Date)*	*(Signature of Witness)*	*(Date)*
(Signature of Personal Representative)	*(Date)*	*(Personal Representative Relationship/Authority)*	