Revoking an Authorization

Individually Identifiable Health Information

You may revoke or restrict an existing authorization by completing this form.

Client's Name: _____ Date: _____

Date of Birth: _____ Telephone: _____

Address: _____
City State Zip Code

You may revoke or restrict an authorization that you have signed while receiving counseling from Wendy Biondi, LMHC by **signing, and returning the completed form by mail or fax to:**

Wendy Biondi, LMHC
140 S. Arthur, Suite 690
Spokane, WA 99202
Fax: 509-535-7073

Revoking an Authorization

This section applies to revocation of signed Release(s) of Information/Authorization(s) that are currently in your client record, which allows Wendy Biondi to disclose your information to another person or entity (such as a doctor or an attorney). Please complete this section by checking the appropriate item below:

☐ I hereby **revoke any and all** authorizations to release my individually identifiable health information to any third party.

☐ I hereby **revoke** my authorization(s) dated _____, which authorizes Wendy Biondi, LMHC to release information to _____

Restricting Uses or Disclosures of Information

This section applies to restrictions you may wish to place on signed Release(s) of Information/Authorization(s) that are currently in your client record. You may restrict access to certain individual(s) by indicating their name(s) and the specific identifiable health information you want to restrict by completing the section below:

I hereby **restrict** my authorization(s) dated _____, which authorizes Wendy Biondi, LMHC to release information to _____

_____

Wendy Biondi, LMHC is hereby notified that she cannot disclose the specific identifiable health information listed:

_____

_____

☐ **I understand that as of the date Wendy Biondi, LMHC receives this revocation, Ms. Biondi will no longer disclose information to the person/entity named in the authorization, except to the extent that Wendy Biondi has relied upon that authorization.**

☐ **I understand that, as of the date Wendy Biondi, LMHC receives this restriction, Ms. Biondi will no longer disclose the specific information identified to the person/entity named in the authorization, except to the extent that Wendy Biondi has relied upon that authorization.**

_____ _____
Signature of Client or Legal Guardian Date

_____
Printed Name of Client or Legal Guardian