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