Bellingham Family Health Clinic
302 36th Street, Bellingham, WA 98225
Phone: 360-756-9793 Fax: 360-752-9007
BellinghamHealth.com

Revocation of Release of Information

Section A: Statement of Revocation

I revoke my previous authorization, or part of my previous authorization, for the Bellingham Family Health Clinic use and disclosure of my health information records. I understand that this revocation of my authorization will *not* affect any action Bellingham Family Health Clinic or others took in reliance on my authorization before receiving this written notice of my revocation.
Initials:_____

Name: _____DOB: _____

Address: _____

City, State, ZIP Code: Phone Number: _____

Copy of authorization attached: Please circle: YES or NO
Date of original authorization (if known): _____

Section B: Description of Authorization Revoked

Do you wish to revoke all of the previous authorization or only part of the previous authorization? Select one of the boxes below and complete all information on this form.

- ☐ Please revoke the entire previous authorization
- ☐ Please revoke only part of the authorization:

Health Information: Describe the health information, including and the dates of the records that were previously authorized for the use or disclosure by Bellingham Family Health Clinic:

_____
_____

Person or Organization Authorized to Use or Disclose: Name or specifically identify the persons or organizations, including Bellingham Family Health Clinic, previously authorized to make use of or disclose the health information described above:

Name: Bellingham Family Health Clinic
Address: 302 36th Street Bellingham, WA 98225
Phone Number: 360-756-9793

Person or Organization to Receive and Use: Name or specifically describe the persons or organizations who had authorized Bellingham Family Health Clinic to disclose or let use the health information described above:
Name: _____
Address: _____Phone Number: _____

Section C: To the patient – Please sign the form.

Signature: _____Date: _____