CHRISTIAN COUNSELING CENTERS OF UTAH

Revocation of Authorization for CCCU to Use or Disclose Health Care Information

Client name: ________________________________ Date of birth: __________

Previous name: ______________________________

Revoke my authorization, dated: _______________

Disclose no more information to:

Name (or title) and organization: ____________________________________

Address: ____

City: ____________________________ State: ___________ Zip: ________

I understand that this request does not apply to any uses or disclosures:

- Before CCCU gets this revocation, or
- Allowed or required by law.

____
Client or legally authorized individual signature

____
Date signed

____
Printed name if signed on behalf of the client

____
Relationship (parent, legal guardian, personal representative)

Received by: **Date received:**

____ _____________
(Signature of CCCU staff member receiving this revocation)