REVOCATION OF AUTHORIZATION TO DISCLOSE INFORMATION

NORTH DAKOTA DEPARTMENT OF HUMAN SERVICES
LEGAL ADVISORY UNIT
SFN 91 (9-2013)

Clear Fields

Client Name	Case Number	Date of Birth

I understand that disclosures made in good faith may have already occurred in reliance upon my previously issued authorization and that this revocation cannot apply retroactively to such disclosures. I also understand that the disclosure of health information may be required by law in some instances, such as for the reporting of communicable diseases.

The North Dakota Department of Human Services and its employees are hereby released from any legal responsibility or liability for disclosure of the information I authorized previously.

I do hereby revoke my Authorization to Disclose Information by the:

Name of Unit

to

Individual/Entity Previously Authorized to Receive your Information	Date Authorization was Signed

Signature of Client or Legal Representative	Date	Time