# REVOCATION OF AUTHORIZATION TO DISCLOSE INFORMATION

DEPARTMENT OF HEALTH AND HUMAN SERVICES
LEGAL DIVISION
SFN 91 (5-2023)

## CLIENT INFORMATION

| Client Name (Last, First, Middle Initial) | | | Date of Birth |
|---|---|---|---|
| Previous Names Used | | | |
| Address | City | State | ZIP Code |
| Telephone Number (if we have questions regarding your request) | | | |

The Department of Health and Human Services (Department) gives you (or your legal representative) the right to revoke an authorization to disclose information, at any time, except to the extent that action has been taken in reliance on it.

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

I hereby revoke my Authorization to Disclose Information by the:

| Name of Section, Unit, Facility, or Program |
|---|
| |

to:

| Person/Agency Previously Authorized to Receive your Information | Date Authorization was Signed |
|---|---|
| | |

| Signature of Client or Legal Representative | Date | Time |
|---|---|---|
| If Legal Representative, Print Name | Relationship to Client | |

**FOR DEPARTMENT USE ONLY**

| Date Received | Date Processed |
|---|---|
| Printed Name of Department Representative | |
| Signature | Date |

| Comments |
|---|
| |