Attn: Outside In Records
1132 SW 13th Avenue, Portland, OR 97205
Main: (503) 535-3800 ■ Records: (503) 445-0984;
FAX (503) 535-3868 ■ Email: records@outsidein.org

REVOCATION OF RELEASE OF INFORMATION

First Name ____ **Last Name** ____

Other Names Used ________________________________ **DOB:** ______/______/______ **Email:** ______________________

The HIPAA Privacy Rule gives you the right to revoke (take back) a release of information you signed in the past. The request must be in writing and does not affect any information that was released before you made this request. Once received, we will place this in your medical record. It will not affect future releases you sign.

(Please initial only one)

________ I revoke the authorization I signed on _____/______/_______ that authorized the release of information to
date

____
person, provider, or facility that you previously authorized a release of information

________ I hereby revoke **ALL** previous authorizations

____ Signature of client or authorized representative

___________________________ Relationship to client

______/______/______ Date

Return to Medical Records by placing in Records box in mailroom or e-mail document to records@outsidein.org **Revocation was documented and uploaded in:** ❒ CPS ❒ OCHIN Epic ❒ Credible **Comments:**	**Accepted by:**