Bear River Mental Health Services, Inc.

90 East 200 North, Logan, Utah 84321 (435-752-0750) ● 663 West 950 South, Brigham City, Utah 84302 (435-734-9449)
440 West 600 North, Tremonton, Utah 84337 (435-257-2168)

REVOCATION OF AUTHORIZATION FOR RELEASE OF RECORDS and/or REQUEST FOR ACCESS

Name: _____ Date of Birth: _____
(person whose information is to be revoked)

(ALL sections of this form must be completed in order to be processed in a timely manner.)

IN REGARDS TO MY PROTECTED HEALTH INFORMATION (PHI), I HEREBY AUTHORIZE BEAR RIVER MENTAL HEALTH SERVICES, INC. TO:

- **REVOKE** immediately, my prior Authorization for Release of Records and/or Request for Access to _____which was scheduled to be in effect until _____.
  Name of Person or Entity Date

☐ I do not want ANY information released to the above mentioned person/entity as of today's date.

☐ I want ONLY the following information,_____
released going forward from the date of signature below.

PLEASE NOTE: Under the law, legal guardians may have access to your (PHI), regardless of revocation on your part.

_____ _____ _____
Client Signature Phone # Date

_____ _____ _____ _____
Personal Representative Signature Print Name Relationship to Client Date
(If client is a minor or incapacitated)

Parent – If parent is divorced or Custody Order is in place, parent must have legal custody of the minor and verification provided by a Court Order.

Legal Guardian - Guardianship must be verified by a Court Order.

Foster Parent - Foster Parent does not have legal custody and is, therefore, NOT a personal representative.

Facilitator and witness to this form: _____ Date _____