



**NOTICE OF REVOCATION**

**Please complete if you are revoking an authorization**

Client: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

I, \_\_\_\_\_, hereby revoke my authorization of disclosure of information to the following person/agency: \_\_\_\_\_.

This revocation effectively makes null and void any permission for disclosure of information given previously. I understand that any disclosures made by CBH based on the previous authorization, prior to receipt of this revocation, will not be affected.

X \_\_\_\_\_  
Signature of Client or Legal Guardian

\_\_\_\_\_  
Date

X \_\_\_\_\_  
Witness's Signature

\_\_\_\_\_  
Date

If you choose to revoke your authorization, please provide a copy of this completed revocation to the Privacy Officer of this agency:

- a) By Mail:      Attn: Privacy Officer  
                         UMSL Center for Behavioral Health  
                         12837 Flushing Meadows Drive, Suite 220  
                         Town and Country, MO 63131
  
- b) By Telephone: 314-516-4357
  
- c) By Fax:        314-516-4863