Sage Neuroscience Center
7850 Jefferson St. NE Suite 300 Albuquerque NM, 87109

Revocation of Release of Information Authorization

Please Print Clearly and Fill Out Form Completely.

I, (print name clearly) _____, revoke my prior Release of Information Form(s) given to Sage Neuroscience Center for the release of my medical, mental health, and/or substance abuse treatment information to the following individual, physician, or organization:

NAME: _____

PHONE: _____

Additional Information (optional): _____

_____

_____

My signature is my acknowledgement that I have read and now voluntarily revoke any and all Release of Information Form(s) signed by me pertaining to the release of my protected health information to the individual, physician, or organization named above.

I understand that Sage Neuroscience Center may have already acted in response to the original authorization in good faith prior to this revocation of the authorization.

Patient Signature: _____ Date: _____

-or-

Guardian Signature: _____

Relationship to Patient: _____ Date: _____