State of Alaska
Department of Health and Social Services
Division of Health Care Services
4501 Business Park Blvd., Suite 24
Anchorage, AK 99503; or
350 Main Street, number 412
Juneau, AK 99811

REVOCATION OF AUTHORIZATION FOR RELEASE OF INFORMATION

(For Non-Enrollment and Non-Eligibility Authorizations)

I do hereby request that the authorization to release the information of _____
(Printed Name of Client)

signed on _____ by _____
(Date of original authorization) (Printed name of person signing original authorization)

for the release of information described as _____
(Description of information released on original authorization)

_____

be revoked, effective _____. I understand that any action taken on this authorization prior to the
(Date)

revocation date is legal and binding. I understand that I may request a copy of this signed revocation.

_____ _____
Client SSN, Record ID or Other ID (if known) Client Date of Birth (if known)

_____ _____
Signature of Client or Personal Representative Date
(Or Witness if signature is by mark)

_____ _____
Printed Name of Personal Representative or Witness Description of Personal Representative's Authority

_____
Signature of Staff

NOTE: This revocation must be attached to the original authorization and the date of the revocation entered on the front side of the original authorization form in the space provided.