REVOCATION FORM
For DHHS Authorization to Release Information

This request applies to the following DHHS office or facility (CHECK ONE):

☐ Office of MaineCare Services  ☐ Substance Abuse and Mental Health Services
☐ Office for Family Independence including Medical Review Team  ☐ Office of Child and Family Services
☐ Maine Centers for Disease Control and Prevention  ☐ Office of Aging and Disability Services
☐ Dorothea Dix Psychiatric Center  ☐ Office of Administrative Hearings
☐ Riverview Psychiatric Center  ☐ Other:

Individual’s Name:  Individual’s Telephone Number:

Individual’s Address:

<table>
<thead>
<tr>
<th>Street</th>
<th>Town/City</th>
<th>State</th>
<th>Zip Code</th>
</tr>
</thead>
</table>

I (individual/personal representative of individual above) hereby revoke (cancel) my previous authorization and take back my permission for DHHS to share records with:

Name of person or office:

<table>
<thead>
<tr>
<th>Street Address of person or office</th>
<th>State and zip code</th>
<th>Email address</th>
</tr>
</thead>
</table>

I understand that this form only applies to future information. Records that were shared with my written permission cannot be taken back.

I understand that this revocation will not be in effect until the DHHS office I checked above receives it.

Date: ____________  Signature_____________________________________________________________________

Personal Representative’s authority to sign (Parent, Guardian, Court Appointment, etc.):

DHHS Revocation of Authorization Form 3/16
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