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:	
Street Town/City State Zip Code	

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

Street Address of person or office

State and zip code Email address

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.):

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