



Winnebago County Department of Human Services
220 Washington Street; PO Box 2187
Oshkosh, WI 54903-2187

Revocation of Authorization for Release and Exchange of Information Form

On _____, I signed an Authorization for Release and Exchange of Information to
(Date)

(Individual/Agency/Division/Team)

I hereby revoke such Authorization effective immediately. I understand that the information may already have been disclosed pursuant to and in reliance on my prior Authorization. I also understand that this revocation applies only to the information specifically described in the above referenced document and does not affect any prior executed Consents to release information for treatment, payment or health care operations, or any prior executed Authorizations for other information.

Consumer/Legal Representative Signature

Date

Consumer Name (print)

DOB

Signature of Witness

Date