NEW YORK STATE
OFFICE OF ALCOHOLISM AND SUBSTANCE ABUSE SERVICES

WITHDRAWAL OF CONSENT FOR RELEASE OF INFORMATION

PATIENT'S LAST NAME	FIRST	M.I.
CASE NO.		
FACILITY	UNIT	

INSTRUCTIONS: **GIVE A COPY OF THE FORM TO THE PATIENT!** Prepare one (1) copy for the Patient's Case Record.

DISCLOSURE WITH PATIENT'S CONSENT

NAME OR TITLE OF PERSON OR ORGANIZATION TO WHICH THE DISCLOSURE WAS AUTHORIZED TO:	
NAME OR TITLE OF PERSON OR ORGANIZATION DISCLOSING INFORMATION FROM:	
DATE OF ORIGINAL AUTHORIZATION	

I, the undersigned, hereby withdraw my authorization to disclose information to the above named individual/organization. except to the extent that action has already been taken in reliance upon it.

I understand that generally the program may not condition my treatment on whether I agree to sign a consent form, but that in certain limited circumstances I may be denied treatment if I do not sign/or withdraw a consent form. I also recognize that there may be consequences if I withdraw a consent to disclose to a legal authority that requires such consent as a condition or release, probation, or parole. I have received a copy of this form, as recognized by my signature below.

_____
(Signature of Patient)

_____
(Signature of Parent/Guardian, when required)

_____
(Print Name of Patient)

_____
(Print Name of Parent/Guardian)

_____
(Date)

_____
(Date)