LEHMANNConsulting
Substance Abuse Counseling and Resources

REQUEST TO REVOKE AUTHORIZATION OF RELEASE OF INFORMATION

I _____ REVOKE THE RELEASE OF INFORMATION ABOUT ME BETWEEN:

Lehmann Consulting, Inc. **Kathrine Lehmann, MA, LADC** **821 Raymond Ave - Ste 320** **Saint Paul MN 55114** **Phone: (612) 306-4778**	AND

Name: _____

Address:_____

City/State/Zip: _____

Attention/Phone:_____

Fax:_____

Please revoke the following authorizations:

_____ All authorizations

_____ **Specific** authorizations as checked below:

_____Assessment and Diagnostic Information
_____Diagnostic and Laboratory Reports
_____Alcohol and Drug Testing Results
_____Progress Updates/Information
_____Chemical Health, Mental Health, and Therapy Notes and Records
_____Care Recommendations/Plan
_____Work or School Progress Reports
_____Financial/Insurance Information
_____ Limited Report:
  _____Dates of Service
  _____Discharge Status
  _____Recommendations/Plan

_____Other (specify) _____

I understand that:

- Lehmann Consulting will continue to be authorized to make disclosures necessary to be paid for services rendered to you on or prior to the date of revocation. You will be held responsible for payment in full for all services rendered to the extent they are not paid on your behalf.
- Please give this form to Kathrine Lehmann in person or mail to Lehmann Consulting, 821 Raymond Ave – Ste 320, Saint Paul MN 55114.

_____ Date_____
Client Signature