Oakland–Berkeley–Alameda County Continuum of Care
Revocation of Release of Information

Client Name: _____

Date of Birth: _____

Medi-Cal CIN (If known): _____

I wish to revoke my authorization to release my personal information.

Signature of Client or Client's Legal Representative:

_____

_____/_____/_____

Month Day Year

If signed by Client's Legal Representative, please give the representative's name, relationship and authority to do so:

Name: _____

Relationship: _____

Authority: _____

(Please send to your Care Team member)