# APEA-AFT Health and Welfare Trust

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**Administered by**
**Welfare & Pension Administration Service, Inc.**

## Revocation of Authorization to Use or Disclose Health Information

1. Name of Trust: _____

2. Identify the individual on whose behalf the authorization was requested:

   Individual's Name: _____ Date of Birth: _____

3. Last 4 digits of Covered Employee's Social Security Number _____

**I hereby revoke the Authorization to Use or Disclose Health Information of the individual identified above, as specified in the authorization form dated: _____.**

**I understand that I cannot revoke any action that was taken prior to the Trust's receipt of this revocation and that was made in reliance on the authorization. I further understand that health information may be used and disclosed as allowed or required by law.**

_____ _____
Signature of individual or legally authorized person Date

_____ _____
Print name if signed on behalf of Individual Relationship
(parent, legal guardian, personal representative)