

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)