Revocation of Authorization Form

On (date) __________________, I signed an Authorization providing for the release of my health information to the person(s) or organization(s) described below. The Authorization allowed the District 9 I.A.M.A.W. Welfare Fund to disclose my Protected Health Information to the person(s) or organization(s) named.

Person(s)/Organization(s) previously authorized to receive my Protected Health Information:

Name: ____

Address: ____

____

I hereby revoke this Authorization.

I understand that the District 9 I.A.M.A.W. Welfare fund may have already taken action in reliance upon my Authorization and that this revocation does not apply to such previous actions.

____ ________________________
Signature of Individual (Personal Representative*) Date

____ ________________________
Print Individual's Name Member ID #

*Please provide a description of the personal representative's authority to act on behalf of the individual:

____

____