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

P.O. Box 34840
Seattle, Washington 98124-1840
Telephone (800) 331-6158 • FAX (206) 441-9110 P62

# 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)