



# Michigan Conference of Teamsters Welfare Fund

## Revocation of Authorization to Release Protected Health Information

### Section #1: Individual Information

I certify that I am (check all that apply):

- A participant (employee/retiree)
- A participant's spouse or surviving spouse
- A non-spousal dependent of a participant
- A personal representative\*

Name of Participant: \_\_\_\_\_  
(print name)

Participant's Contract Number: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Participant's Birth Date: \_\_\_\_/\_\_\_\_/\_\_\_\_  
MM / DD / YR

You can contact me at:

Home Telephone Number: \_\_\_\_\_ E-mail: \_\_\_\_\_

Work Telephone Number: \_\_\_\_\_

I would like to revoke my previous authorization to release information on (check only one):

- Myself (print name) \_\_\_\_\_
- My dependent minor child (print name) \_\_\_\_\_
- A covered individual for whom I am the personal representative\* (print name) \_\_\_\_\_

*\*Note: If you are a personal representative of the individual and you are completing this form on behalf of the individual, you must complete the personal representative area found in Section #2. Personal representative means a person with legal authority (under State or applicable law) to act on behalf of the individual in making health care decisions.*

I, \_\_\_\_\_ (print name), hereby revoke the authorization for the person(s) and/or organization(s) identified on my authorization form, dated \_\_\_\_\_, to use or disclose my protected health information (as defined in the Privacy Rule of the Administrative Simplification provisions of the Health Insurance Portability and Accountability Act of 1996) for the identified individual in Section #1. I understand that this revocation will become effective upon receipt of this completed form except to the extent that the Michigan Conference of Teamsters Welfare Fund (the Fund) has already taken action in reliance on my previous authorization.

I, \_\_\_\_\_ (print name), have reviewed this form and understand its contents. I have signed this form voluntarily to document my wishes to revoke my previous authorization regarding the use and/or disclosure of health information.

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
Signature MM DD YR Date of Signature

Address: \_\_\_\_\_  
\_\_\_\_\_



## Michigan Conference of Teamsters Welfare Fund Revocation of Authorization to Release Protected Health Information

### Section #2: Personal Representative

If signed by a personal representative, complete the following:

Name of personal representative: \_\_\_\_\_  
(print name)

Name of individual you are representing: \_\_\_\_\_  
(print name)

Relationship to individual or nature of authority (e.g., parent of an unemancipated minor, unlimited guardian pursuant to letters of authority, personal representative pursuant to letters of authority, parent advocate pursuant to a health care power of attorney, other statutory authorization): \_\_\_\_\_  
\_\_\_\_\_

*Note: You must provide valid and current proof of your legal relationship as a personal representative.*

#### Personal Representative Contact Information

Address: \_\_\_\_\_  
\_\_\_\_\_

Home Telephone Number: \_\_\_\_\_ E-mail: \_\_\_\_\_

Work Telephone Number: \_\_\_\_\_

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_ Date of Signature  
Signature of Personal Representative MM DD YR

### Section #3: Submission Instructions

Submit Form to: Privacy Officer  
Michigan Conference of Teamsters Welfare Fund  
2700 Trumbull Avenue  
Detroit, MI 48216