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

Section #1: Revoking Individual Information

Name _____ Birth Date _____/_____/_____
Please Print MM / DD / YR

Contract Number _____ or Social Security Number _____
(Found on ID card)

Address _____

City _____ State _____ ZIP Code _____

Telephone Number _____ E-mail _____

Section #2: Authorization to be Revoked

I hereby revoke the authorization for the person(s) and/or entity (or chasses of persons and/or entities) 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.

Section #3: Revocation and Signature

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.

_____ Date of Signature _____/_____/_____
Signature MM / DD / YR

☐ I am the personal representative for the member.*

**Note: 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. Please complete Section #4.*

Section #4: 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., health care power of attorney, guardian, other statutory authorization):

_____*Note: If other than natural parent of a minor child, valid and current proof of legal relationship as personal representative must be provided.*

Personal Representative Contact Information

Address _____ Telephone Number _____

_____ E-mail _____

_____ Date of Signature _____/_____/_____
Signature of Personal Representative MM / DD / YR

	Privacy Officer
Submit Form to:	***Michigan Conference of Teamsters Welfare Fund***
	2700 Trumbull Avenue
	Detroit, MI 48216
Or Fax to:	***313-496-2943***