

# Alaska United Food and Commercial Workers Trust Funds

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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)