Iron Workers Health Trust Fund Local No. 5
Washington D.C. Welfare Fund

Physical Address 7525 SE 24th Street, Suite 200, Mercer Island, WA 98040 • Mailing Address PO Box 34203, Seattle, WA 98124
Phone (206) 441-7314 or (877)367-0541 • Fax (206) 505-9727 • Website: www.iw5benefits.org

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)

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07/01/2022