NATIONAL IAM
BENEFIT TRUST FUND

CANCELLATION OF AUTHORIZATION FORM
(Relating to Use or Disclosure of Protected Health Information)

Your Name (Please Print) _____ Your Social Security Number _____

If you are the dependent of a covered employee, please provide the name and Social Security Number of the covered employee:

Employee Name (Please Print) _____ Employee Social Security Number _____

I hereby cancel any existing Authorization Form that allows the Benefit Trust Fund to provide my Protected Health Information ("PHI") to the following person(s): (please fill in the name and address of the appropriate person(s))

☐ _____

☐ Attorney: _____

☐ Other Person(s): _____

☐ All Authorizations

I understand that:

- **THIS FORM REVOKES ANY PREVIOUS AUTHORIZATION FORM ONLY WITH RESPECT TO THE PERSON(S) NAMED ABOVE. IF I DECIDE TO REAUTHORIZE THIS PERSON(S), I WILL NEED TO SUBMIT A NEW COMPLETED AUTHORIZATION FORM TO THE PLAN.**
- **CANCELLATION WILL TAKE EFFECT ONCE THE FUND RECEIVES THIS FORM.**
- **THE FUND WILL PROVIDE A COPY OF THIS SIGNED CANCELLATION OF AUTHORIZATION FORM TO ME OR MY PERSONAL REPRESENTATIVE.**

Your Signature (or Signature of Personal Representative*) _____ Date _____

* If you are acting as the Personal Representative of the individual whose PHI is to be disclosed, you must provide proof of your authority to act for that individual.

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