



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.

Revised 01/2017