Welfare Fund
PHI Cancellation Form

A B C D E F G H I J K L M N

PLUMBING INDUSTRY BOARD
PLUMBERS LOCAL UNION No.1
50-02 5th Street, Long Island City, New York 11101
Tel. (718) 835-2700

(For Use or Disclosure of Protected Health Information)

Use a ballpoint pen to complete form

PURPOSE OF THIS FORM

The U.S. Department of Health and Human Services has issued regulations establishing strict standards on how health plans may use and disclose your medical records. In order for the Plumbers Local Union No. 1 Welfare Fund ("Fund") to use or disclose your Protected Health Information to someone other than you, you must complete this Authorization Form and return it to the Fund.

Protected Health Information ("PHI") is information that is created, received, transmitted or stored by the Fund which relates to your past, present, or future physical or mental health, health care, or payment for health care, and either identifies you or provides a reasonable basis for identifying you. Except as permitted by law, the Fund may not use or disclose PHI to persons other than those you specify on this form.

(A) Request for Plumbers Local Union No.1 Welfare Fund to Cancel Previous Authorization to Disclose Protected Health Information for

[redacted] [redacted] [ ][ ][ ][ ] _____ _____ _____

(1) Identification Number (2) Last (3) First (4) Init.

Your relationship to Member(5) ☐ Self ☐ Spouse ☐ Dependent ☐ Other _____

B): Cancellation of Authorized Person *(Please print name)*

I hereby cancel any existing authorization form that allows the Fund to disclose my protected health information (PHI) to the following person: ***(please designate no more than one person and fill in their name and address)*** **(1)**

☐ Spouse ☐ Union Representative ☐ Attorney ☐ Other Person _____
Relationship

_____ _____ _____ (_____)_____-_____

Last Name(2) First Name(3) Init.(4) Telephone Number(5)

_____ _____ _____ _____

Street(6) City(7) State(8) Zip(9)

(C): Acknowledgment and Signature

I understand that:

- **This form revokes any previous authorization form only with respect to the person named above. If I decide to reauthorize this person, I will need to submit a new complete authorization form to the Fund.**
- **Cancellation will take effect once the Fund receives this form.**

_____ _____

Your Signature (or Signature of Personal Representative*)**(1)** Date**(2)**

*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.

Fund Office Use Only Date Mailed: _____ Processed By: _____ Status: _____

WF-HIPAA-AF/11.2016