Revocation of HIPAA* General Authorization for Disclosure of Protected Health Information (PHI)/(ePHI)

***Health Insurance Portability and Accountability Act of 1996**

Mid-America Carpenters Regional Council Health Fund (Fund)
St. Louis-Kansas City Region
1419 Hampton Avenue, St. Louis, MO 63139 *Attn: Privacy Officer*
Phone: (314) 644-4802, option 1 | Fax: (314) 678-1110 | Email: benefits@laborfunds.org

Reset form

Complete electronically or print clearly using black or blue ink. This form requires you to print, sign, and return to our office.

This form revokes or terminates permission to disclose PHI/ePHI to a previously authorized Person or Entity.

SECTION 1: COVERED INDIVIDUAL TERMINATING AUTHORIZATION TO DISCLOSE PHI/ePHI

Covered Individual Full Name (Last, MI, First)	Last 4 Social Security Number (SSN) or UMR/UHC ID
Date of Birth	Cell Phone Number

SECTION 2: REVOCATION OF AUTHORIZATION

I revoke any authorizations I have previously given to the Plan to disclose my protected health information to the following Person or Entity.

Full Name of Person or Entity previously authorized to receive PHI/ePHI (Last, MI, First)	Relationship	Phone Number
Full Name of Person or Entity previously authorized to receive PHI/ePHI (Last, MI, First)	Relationship	Phone Number

The Fund may no longer disclose the following PHI/ePHI to the Person/Entity listed above (choose all that apply):

☐ My complete health record maintained by the Fund ☐ Other, please specify: _____

IMPORTANT INFORMATION CONCERNING COVERED INDIVIDUAL RIGHTS

1. The Covered Individual is the participant or dependent covered under the Mid-America Carpenters Regional Council Health Fund.
2. The Covered Individual's signature on this form will not affect your treatment, payment, enrollment in health plan or eligibility for benefits.
3. Upon request, a copy of this signed Authorization will be sent to the Covered Individual listed in Section A.
4. If signed by a legally authorized Personal Representative (Power of Attorney, etc.), legal documentation must be attached.
5. Any revocation will not apply to any action that the Plan may have already taken on the Covered Individual's behalf before receipt of the signed Revocation of HIPAA Authorization Form.

SECTION 3: COVERED INDIVIDUAL ACKNOWLEDGEMENT AND SIGNATURE

By completing and signing this form, I understand and agree I am now revoking my prior HIPAA Authorization to release my PHI/ePHI to the person or entity listed above. I also understand that this revocation will not affect any action the Fund may have already taken in reliance on my authorization before they receive this written notice.

X _____ _____

Covered Individual Signature (or Legal Personal Representative, see #4 above) Date

X _____ _____

Legal Name of Personal Representative (if applicable) Personal Representative Phone Number

Mail, fax, or email this completed form to the address at the top of this form, Attn: Privacy Officer.

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