Alaska Laborers Trust Funds

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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)