

Revocation (Withdrawal) of HIPAA Authorization

Name: _____ Date of Birth: _____

Member ID#: _____

Address: _____

On _____ (insert date if known), I signed a HIPPA Authorization Form permitting the Greater St. Louis Construction Laborers' Welfare Fund to use and/or disclose my medical information.

I revoke (withdrawal) the authorization I provided on that date.

I understand that the Greater St. Louis Construction Laborers' Welfare Fund may have already taken action based on the authorization I provided and this withdrawal does not change this action.

Signature

Date

Name of the Individual to Withdrawal

Relationship

Return this completed form to:
Laborers' Benefit Office
Benefit Services Department
2357 59th Street
St. Louis, MO 63110-2811