AUTHORIZATION REVOCATION FORM

You previously authorized the AFTRA Health Fund ("Fund") and its respective agents and employees to release your Protected Health Information ("PHI") to a party designated by you. If you no longer wish the Fund to disclose information to that party, you must submit a complete and signed copy of this form to the following address:

Privacy Officer
AFTRA Health Fund
261 Madison Avenue
New York, NY 10016

Name: _________________

Relationship to Participant
- ❐Self
- ❐Spouse
- ❐Eligible Dependent

Participant's SSN: _______________

I hereby revoke my authorization to the Fund to release any PHI to:
Name ________________
Address_______________________
To be effective as of: ___________________

I understand the Fund will accept this authorization only to the extent that no reliance was made upon it.

I have had the opportunity to review and understand the content of this Authorization Revocation Form. By signing this cancellation, I am confirming that it accurately reflects my wishes.

Signature of __________________________________ Date________
Participant/Eligible Dependent/Personal Representative

If signed by someone other than a Participant, Spouse or Eligible Dependent, please state your relationship and authority to do so ____

FOR OFFICE USE:
Date request received: _____________

- ❐ Request Granted
- ❐ Request Denied

Individual notified in writing on this date ___________________ (attach letter of communication)
Signature/Title of staff member processing request: ____________________________