Print Name of Member _____ Social Security #_____

National Elevator Industry Health Benefit Plan
19 Campus Blvd., Suite 200
Newtown Square, PA 19073
1-800-523-4702

CANCELLATION OF AUTHORIZATION FORM

_____ _____
Print Name of Individual/Patient (as stated on Authorization Form) SS# of Individual/Patient

I hereby cancel any existing Authorization Form that allows the Benefits Office to provide my Protected Health Information ("PHI") to the following person(s): (please fill in the name and address of the appropriate person(s)

□ Spouse_____

□ Any representative of my local union # _____ □ Specific representative only_____

□ Attorney_____

□ Other Person(s) _____

□ All Authorization Forms on file with the Benefits Office.

I understand that:

- **THIS FORM REVOKES ANY PREVIOUS AUTHORIZATION FORM ONLY WITH RESPECT TO THE PERSON(S) NAMED ABOVE. IF I DECIDE TO REAUTHORIZE THIS PERSON(S) I WILL NEED TO SUBMIT A NEW COMPLETED AUTHORIZATION FORM TO THE BENEFITS OFFICE.**
- **CANCELLATION WILL TAKE EFFECT ONCE THE BENEFITS OFFICE RECEIVES THIS FORM.**

_____ _____
Your Signature (or Signature of Personal Representative*) Date

*If you are acting as the Personal Representative of the individual whose PHI is subject to disclosure, you must provide proof of your authority to act for that individual.

(A copy of this Cancellation of Authorization Form will be sent to you or your Personal Representative upon request.)