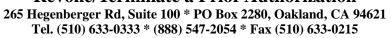
Carpenters Health and Welfare Trust Fund for California Revoke/Terminate a Prior Authorization





	1e:	SSN, CFAO ID#, or UBC#:
		, hereby revoke/terminate an authorization that I made o
	, 20 regarding the use	or disclosure of my health information.
	Specific person/organization (or class of perso	ns) who was authorized to provide the information:
	Specific person/organization (or class of perso	ns) who was authorized to receive and use the information:
	Specific description of the information that was allowed to be used or disclosed.	
	(Include dates as appropriate):	
	I understand that the revocation/termination is only effective after it is received and logged by the Privacy Officer. understand that any use or disclosure made prior to the date of this revocation/termination will not be affected by thi revocation/termination request.	
:	-	nor to the date of this revocation/termination will not be affected by thi
;	-	Date
:	revocation/termination request.	
:	revocation/termination request.	Date or
	Signature of Individual Signature of Personal Representative	Date or
	Signature of Individual Signature of Personal Representativ If a Personal Representative executes this for	Date or Date Date