WEA trust
PO Box 259537 | Madison, WI 53725-9537
800.279.4000 WEAtrust.org

END AUTHORIZATION TO SHARE HEALTH INFORMATION

If you want WEA Trust to stop sharing your health information with a person or agency that you authorized in the past, complete the **End Authorization to Share Health Information** form.

INSTRUCTIONS FOR COMPLETION

1. Print or type.

2. Use blue or black ink.

3. **Individual's Name:** Your name or your dependent's name.

4. **Birth date:** Your birthdate or your dependent's birthdate.

5. **Subscriber Number/Group Number:** Your (or your dependent's) WEA Trust subscriber number and group number.

6. **End Authorization:** Who is the person or agency that should no longer receive your health information?

7. **Individual's Signature:** The person from #3 must sign the form.
   - If a dependent is under 18, the parent/legal representative must sign the form.
   - If an adult cannot sign the form, the parent/legal representative must sign the form and write why they are signing (disability or health condition).

8. **Date:** What date are you signing the form?

9. Send the form to:

   WEA Trust
   Attn.: Office of General Counsel
   PO Box 259537
   Madison, WI 53725-9537

   Fax: 608.276.9119, Attn.: Office of General Counsel

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END AUTHORIZATION TO SHARE HEALTH INFORMATION

Individual's Name: _____ **Individual's Birth Date:** _____

Subscriber Number: _____ **Group Number:** _____

End Authorization
I want WEA Trust to stop sharing my health information with: _____

_____

I understand that I gave WEA Trust permission to share my health information with this person or agency in the past. I cannot change any information WEA Trust shared before receiving this form.

_____
Individual's Signature

_____
Date

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