Authorization For Release of Health Information

I. Information About the Use or Disclosure

I hereby authorize the use or disclosure of my individually identifiable health information as described below. I understand that this authorization is voluntary and that I may revoke it at any time by submitting my revocation in writing via delivery of such revocation to the Privacy Official (subject to the conditions described in II below).

Name_____ Employee ID Number or DOB_____

Persons/organizations authorized to provide the information: _____

_____

Persons/organizations authorized to receive the information: _____

_____

Specific description of information to be used or disclosed:_____

_____

Specific purpose of the disclosure: _____

_____

This authorization is effective _____ and will expire _____.

If no expiration date is indicated, the authorization will expire 365 days following the date of original authorization.

II. Important Information About Your Rights

I have read and understood the following statements about my rights:

- I may revoke this authorization at any time prior to its expiration date by notifying the Medical Plan via delivery to the Privacy Official in writing. I understand that the revocation is only effective after it is received and logged by the Privacy Official on behalf of the Medical Plan. I understand that any use or disclosure made prior to the revocation unde this authorization will not be affected by the revocation.
- I may see the copy this authorization form if I ask for it.
- I am not required to sign this form to receive my health care benefits (enrollment, treatment, or payment).
- The information that is used or disclosed pursuant to this authorization may be re-disclosed by the receiving entity.

Signature of Employee (or Employee's representative) _____ Date _____

Printed name of the employee's personal representative: _____

Relationship to employee, including authority for status as representative:

_____

_____