

AUTHORIZATION TO RELEASE PROTECTED PERSONAL HEALTH INFORMATION

I, _____, hereby authorize _____ to disclose my Protected Health Information to _____ as described in this authorization.
(print name) (provider or health plan) (college/university name and address)

1) The person or class of persons authorized to provide the information is: _____
(name or describe employees of provider/health plan who can release the information)

2) The person, organization, or class of persons authorized to receive and use the information: _____
(college/university HR office and/or staff members)

3) The information that may be used or disclosed is (check all that apply):
 Medical information from the following doctor, clinic, or hospital: _____

 Information held by the Health Insurance Plan concerning payment of claims.
 Other. Please specify: _____

4) Right to revoke: I understand that I have the right to revoke this authorization at any time by notifying the _____ in writing at _____.
(provider/plan) (provider/plan address)
I understand that the revocation is only effective after it is received and logged by the provider/plan. I understand that any use or disclosure made prior to the revocation under this authorization will not be affected by a revocation.

5) I understand that, after this information is disclosed, federal law may not protect it and the recipient might redisclose it. I also understand and agree to hold _____, _____ or their agents and subcontractors harmless if information is redisclosed.
(provider/plan) (college/university name)

6) I understand that I am entitled to receive a copy of this authorization.

7) I understand that this authorization will expire on _____ or under these circumstances: _____
(date)

8) This is an authorization to provide an employer with protected health information. The Covered Entity (provider or plan) may not condition treatment, payment, enrollment, or eligibility for benefits on whether the Covered Person signs the authorization when the prohibition on conditioning of authorizations applies. An authorization can be conditioned, in part, on: health plan eligibility, enrollment and underwriting; and the provision of health care that is solely for the purpose of creating protected health information for disclosure to a third party [164.508 (b) (4)].

Signature of Covered Person: _____ Date _____

Personal Representative. I represent and warrant that I am the Personal Representative for the Covered Person specified above and am signing this form in my capacity as Personal Representative.

Describe your authority or relationship to the Covered Person: _____

Signature of Personal Representative _____ Date _____