HIPAA Privacy Rule Authorization for Release of Health Information

I, _____ authorize the specified person(s) to disclose
[Employee Name]
protected health information as follows:

1. Person authorized to make disclosure: _____
[Name of health care provider, insurer, company's employee benefits plan, etc.]

2. Person authorized to receive the disclosed information: _____
[Name of your company]

3. Specific description of the protected health information that may be used or disclosed:

   _____

   _____

   _____.

4. I understand that the information received pursuant to this authorization may be disclosed by the recipient and might lose its protected status.

5. I understand that I may revoke this authorization at any time by giving written notice to

   _____.
   [Name of person in your company who must receive the written revocation or CMS]

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

7. I understand that after this information is disclosed, federal law might not protect it and the recipient might re-disclose it.

8. I understand that my initial and continued employment and position are subject to my agreement to this authorization, and any additional authorization

   _____ requests.
   [Name of your company]

9. I understand that this authorization will expire when my employment with _____ terminates or when I am no longer covered
   [Name of your company]
   by the company's employee benefits plan or COBRA plan, whichever is later.

Signature of Employee: _____ Date: _____

Name: _____

If a Personal Representative executes this form, that Representative warrants that he or she has authority to sign this form on the basis of: _____.
[Description of personal representative's authority]