Print Form

AUTHORIZATION FOR USE AND DISCLOSURE OF HEALTH INFORMATION

Introduction

I hereby authorize the use and/or disclosure of my individually identifiable health information as described herein. I understand that this authorization is voluntary. Except for the below-stated protections accorded ALCOHOL AND DRUG ABUSE records, I also understand that the information released hereby may no longer be protected by federal privacy regulations if the organization authorized to receive said information is not a health plan or health care provider.

Employee/Patient Name: _____

Employee/Patient DOB: _____

Persons/organizations providing information: Persons/organizations receiving information:

_____ _____

_____ _____

_____ _____

Specific Description of Information

All pertinent information related to diagnoses of and treatments for _____ _____ [physical/mental health conditions] from _____ [date] through _____ [date].

Scope of Authorization

I authorize and direct you to discuss my health information with and to permit the examination and copying of related documents if requested by [Agency/School District/Higher Education Institution]. You are also authorized to disclose related health information at my request from time to time without the need for another formal authorization.

Alcohol/Drug Abuse Records

I understand that, if relevant, this consent is sufficient to include disclosure of ALCOHOL AND DRUG ABUSE records, IF ANY, which are protected by the provisions of Federal Regulation 42 CFR Part 2. This consent is premised upon the requirement that all disclosures of alcohol and drug abuse records, if any, made pursuant to this authorization shall be accompanied by the following notice:

> NOTE: This information has been disclosed to you from records whose confidentiality is protected by Federal Law. Federal Regulation (42 CFR Part 2) prohibits you from making any further disclosure

Purpose of Requested Use and Disclosure

To assist me and my employer in the evaluation of my personal health conditions and their impact upon my ability to perform the essential functions of my job with or without a reasonable accommodation in accordance with the Americans with Disabilities Act.

Expiration/Revocation/Option to Refuse

The authorizing individual (or his/her authorized representative) must read and initial the following statements:

1. This authorization will expire on _____/_____/_____. Initials:_____
2. I may revoke this authorization at any time by notifying the parties in writing. A written revocation will not affect on any actions taken prior to its receipt. Initials:_____
3. I understand that I may refuse to sign this authorization. Initials:_____
4. Photocopies of this signed authorization shall be treated as executed originals. Initials:_____

_____ _____

Signature of Employee/Patient/Personal Representative Date

Printed Name:_____

Description of, or basis for, authority to act on behalf of authorizing individual (if applicable):

_____