AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

I _____ [Employee Name] hereby authorize the use or disclosure of my health information as described in this authorization.

(1) Specific person/organization (or class of persons) authorized to provide the information:

_____

(2) Specific person/organization (or class of persons) authorized to receive and use the information:

_____

(3) Specific and meaningful description of the information:

[For example, medical examination report and conclusions related to a fitness-for-work exam, or results of drug testing for employment-related purposes.]

_____

(4) Purpose of the request:

(Please state the purpose of the request below. If you do not wish to state a purpose, please state, "At the request of the individual.")

_____

(5) Right to revoke: I understand that I have the right to revoke this authorization at any time by notifying [Employer or Plan Sponsor] in writing at [list address where revocation must be delivered]. I understand that the revocation is only effective after it is received and logged by [Employer or Plan Sponsor]. I understand that any use or disclosure made prior to the revocation under this authorization will not be affected by a revocation.

(6) I understand that after this information is disclosed, federal law might not protect it and the recipient might redisclose it.

(7) I understand that my initial and continued employment and position are subject to my agreement to this authorization, and any additional authorization [Employer] requests.

[Employers must review their employment handbooks and any applicable collective bargaining or state-law restrictions to ensure that the authorization does not conflict with other employee rights or requirements (imposed either voluntarily or by law).]

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

(9) I understand that this authorization will expire when my employment with [Employer] terminates.

[The authorization must include a terminal date based on a specific date or event. Here, the event used is the termination of employment. If an employer or plan sponsor desires to extend the time for post-employment use of authorizations, it must modify item 8 accordingly.]

Signature of Employee_____ Date _____

Personal Representatives section

If a Personal Representative executes this form, that Representative warrants that he or she has authority to sign this form on the basis of:_____