HIPAA AUTHORIZATION FOR DISCLOSURE/USE OF PERSONAL HEALTH INFORMATION

I, _____ an employee or applicant of _____, (hereafter, "Employer") hereby grant authorization under the Health Information Portability and Accountability Act, as follows:

DISCLOSURE AUTHORIZATION-CHECK & INITIAL THOSE THAT APPLY:

_____ ☐ _____, **a health care provider with _____ is specifically authorized to disclose the personal health information identified below, concerning me to the person, designated below.**

_____ ☐ _____, (insert name or class of persons) with _____, a health plan or health care clearinghouse, is specifically authorized to disclose the specific personal health information identified below, concerning me to the person, designated below.

_____ ☐ _____, an authorized representative of my Employer, named above, is specifically authorized to disclose the specific personal health information identified below, concerning me to the person, designated below.

RECEIPT/USE AUTHORIZATION- CHECK & INITIAL THOSE THAT APPLY:

The above-named person(s) is/are authorized to disclose, and the following designated individuals (by name or class of persons) are authorized to use the personal health information, identified below:

☐ _____, an authorized representative of my Employer.

☐ _____, an authorized representative of a health plan or health care clearinghouse: _____

☐ _____, a health care professional affiliated with the following facility: _____

☐ _____, an authorized representative of a scientific or testing laboratory or facility: _____

☐ _____, a representative of: _____

PERSONAL HEALTH INFORMATION TO BE DISCLOSED:

_____

PURPOSE OF DISCLOSURE- CHECK ALL THOSE THAT APPLY:

☐ Post-offer/pre-employment physical examination
☐ Investigation of mistake, fraud, accounting errors in payment of claims, benefits, administration
☐ ADA assessment, compliance, accommodation efforts, interactive process, direct threat assessment
☐ FMLA Certification, 2nd and 3rd examination process (but not additional FMLA information from Employee's health care provider beyond the initial certification.)
☐ Diagnosis, assessment, treatment of work-related injury or alleged work-related injury
☐ Explanation of work restrictions, duration of restrictions or clarification of doctor's note/slip
☐ Workers' compensation investigation, claims assessment
☐ Verification of attendance and leave issues, hours worked/off
☐ Investigation of rule, policy issues or litigation claims
☐ Other: _____ _____

My refusal to sign this form will not adversely affect my ability to receive health care services, reimbursement for services, enrollment in a health plan or my eligibility for health benefits. However, information will not be released to the above-indicated recipient without my signature. I acknowledge that the information disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer protected by Federal Law. I acknowledge that I have the right to revoke this authorization by written notice to the Healthcare Provider listed above. I understand that actions taken in reliance on this authorization cannot be reversed, and my revocation will not affect those actions.

This authorization expires on: _____ or upon the following event: _____

Employee/Applicant **Employer Representative** Date
(photo/fax copies as good as originals)