**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 <u>& INITIAL</u> 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 <u>& INITIAL</u> 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:______________________________

I understand that any person receiving my personal health information may re-disclose such information, which may no longer be protected by HIPAA

PERSONAL HEALTH INFORMATION TO BE DISCLOSED:

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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: ____

____
Expiration Date/Event

______________________________ ______________________________________ ________________

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

Employee at all times retains the right to revoke this authorization in a writing provided to the Employer Representative whose name appears above. Revocation may not be effective to the extent action has been taken.
Information provided pursuant to the instant authorization may no longer be protected under federal privacy law.