AUTHORIZATION TO RELEASE MEDICAL INFORMATION TO EMPLOYER

TO COMPLY WITH THE HEALTH CARE PORTABILITY AND ACCOUNTABILITY ACT (HIPAA)

Applicant/Employee Name:	
Address:	Telephone Number:
Insurance ID# (if applicable):	
Employer Name:	
Address:	Telephone Number:

The following individual(s) is authorized to receive my protected health information:

Employer Representative	Job Title and/or Department
Employer Representative	Job Title and/or Department

The following health care provider or carrier is authorized to release my protected health information:

Address:	Telephone Number:

Detailed description of information that may be used and disclosed:

This information is being disclosed ☐ at the request of the employee **OR** for the following purpose:

Expiration date/event for disclosing the information described above to my employer:

I authorize the health care provider/carrier listed above to disclose the information described on this form to my employer's representative(s). I understand that I have the right to revoke this authorization at any time by submitting a written notice to the health care provider/carrier. I further understand that the health care provider/carrier may not condition my treatment, payment, enrollment, or eligibility for benefits on whether I sign this authorization form. I am aware that the information disclosed to my employer may be subject to re-disclosure and thus no longer protected by the privacy regulations of the Health Care Portability and Accountability Act (HIPAA).

Applicant/Employee Name or Personal Representative*	Date

*If personal representative's signature, please describe authority to act for the applicant/employee: