Authorization for Disclosure of Protected Health Information

Section 1

Member Information (Please Print)

Date: _____
Name: _____
Address: _____
_____

Member ID_____
(ID number on your health identification card)
DOB: _____
Telephone: _____

Section 2

I authorize _____ and its affiliates to disclose the above individual's
(Health Plan/Payer Name)
"protected health information" to **_Lee Robinson, Employee Relations Manager, Swarthmore College, Swarthmore, PA 19081-1397 ___**_____

(You must include the name, address and phone number of the person or entity receiving the information)

Description of Information to be Disclosed: **medical information relating to current disability and what accommodations may be reasonable and appropriate.**
Purpose of Disclosure:

Section 3

I understand that the health plan needs my specific authorization to release my protected health information pertaining to the items listed below. An authorization for psychotherapy notes cannot be used for any other type of information. By initialing, I authorize release of the information pertinent to my case:

Genetic Information	_____*(Initials)*
Psychotherapy Notes	_____*(Initials)*
Mental/Behavioral health information	_____*(Initials)*
Chemical dependency (includes Alcohol/drug treatment)	_____*(Initials)*
HIV/AIDS	_____ *(Initials)*

Section 4

My **protected health information** is information about me, including information such as my name and address and/or medical information. The information was used or created when I received health care or when payment was received for my health care. The information may include my past, present or future physical or mental health or condition.

I understand that if the persons or organizations I authorize to receive and/or use the protected health information described above are not subject to federal health information privacy laws, they may further disclose the protected health information and it may no longer be protected by federal health information privacy laws.

I understand that my authorizing the use and disclosure of my "protected health information" is not a condition of my enrollment in your health plan, my eligibility for benefits or payment of my claims.

Section 5

Expiration: This authorization will expire on ___/___/___ or on occurrence of the following event
_____
(The above must relate to the purpose of the use and/or disclosure being authorized.)

You may revoke this authorization at any time by contacting the Human Resources department. Your revocation of this authorization will not affect any action we take before we receive your notice of revocation.

Section 6

Signature: _____ Date: _____
(Person Granting Authorization)
If this authorization is signed by a personal representative on behalf of the individual, complete the following:
Personal Representative's Name: _____
(Please Print)
Description of Personal Representative Authority: _____