

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: _____

4. Purpose of the request: _____
5. Right to revoke: I understand that I have the right to revoke this authorization at any time by notifying the Plymouth-Canton Community Schools HIPAA Privacy Official, Dawn McBeath, in writing at 454 S. Harvey Street, Plymouth, MI 48170, telephone (734) 416-4834. I understand that the revocation is only effective after it is received and logged by the Privacy Official. 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 re-disclose it.
7. I understand that I am entitled to receive a copy of this authorization.
8. I understand that this authorization will expire when my employment with Plymouth-Canton Community Schools terminates.

Signature of Employee _____

Date _____

Personal Representative 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: _____