TASC
HIPAA Compliance

Employee Authorization to Allow Disclosure of Protected Health Information (PHI)

Employer: _____

Employee Name: _____

- Date of Birth _____
- Daytime Phone: _____
- Email Address: _____

I hereby authorize my employer to allow _____ (Identify the person or organization in detail) access to my Personal Health Information for the following purpose:

_____

_____

_____

The following PHI may be released per this Authorization (describe the PHI that may be released):

_____

_____

_____

Access to my Personal Health Information is limited as follows (describe any PHI that may not be released):

_____

_____

_____

I understand I may revoke this Authorization in writing at any time.

This Authorization is to remain in full force and effect until my employer receives written notification from me of its revocation, or it will expire on _____. If left blank the Authorization will remain in effect for 10 days from date of signature below.

Failure to allow this or any other Authorization will in no way affect the Plan benefits I receive.

Employee Signature: _____ Date: _____

First and Last Name Printed: _____