HIPAA AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

Individual's Name:	**Date of Birth:**
Address:	**Phone Number:**
Personal Representative's Name and Address (if applicable):	

INSTRUCTIONS

1. Complete all applicable areas of the authorization.
2. If you are the personal representative of the requesting individual, include a copy of the legal document(s) authorizing you to act on the individual's behalf.
3. Sign and provide this authorization to the relevant health care provider.

The person(s) or organization(s) I am authorizing to share my information: Any UP Health System treating physicians or other health care providers, specialists, therapists, hospitals, clinics, laboratories, pharmacies, rehabilitation specialists, vocational evaluators, insurance carriers, and all other medical-related providers, facilities, or services.

The information indicated below can be provided to _____.
(Employer Name)

The disclosure is at the request of the above-named individual/personal representative to assist my Employer and its authorized representative, including all persons at the Employer who are authorized to have access to Protected Health Information, in evaluating pre-employment screenings or other occupational health-related screenings and assessments.

The information to be used or disclosed:

Medical information and records related to pre-employment screenings or other occupational health related screenings and assessments, including urine drug screens, breath alcohol technician (BAT) results, urine dip, audiogram results, vision tests, spiro, lab results, x-rays, any physical exam, respiratory exams, and any other medical information necessary for pre-employment screenings or other occupational health related screenings and assessments as requested by the Employer listed above.

Any additional information or exceptions: _____

Date range (If applicable): **From _____ to _____**

I hereby authorize the use or disclosure of my information, and I understand that:

1. I may refuse to sign the authorization.

2. I have the right to revoke this authorization at any time in writing. However, any action taken based on this authorization cannot be reversed, and my revocation will not affect any action that has already been taken.

3. Unless I revoke this authorization, or my Employer changes requiring the execution of a new authorization, it will expire one year from the date of the signature below.

4. By signing below, I recognize that the health information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient(s) and the information may no longer be protected by certain state or federal privacy laws or regulations, including HIPAA.

5. My health care provider may not condition treatment or payment on whether I sign this form.

6. A copy of this authorization is available to me on request.

Name (Print)	DOB
Signature of the Individual	Date
Signature of the Personal Representative, if applicable	Date
Relationship of the Personal Representative to the Individual	

***❑ Authority Attached** *In non-emergency situations documentation of authority must be attached if anyone other than the patient signs this authorization.*