Sample HIPAA Compliant Authorization

Employee Authorization for Disclosure of Protected Health Information

ABC Corporation

I, (Print Employee Name)_____ hereby authorize the use or disclosure of my health information as described in this authorization.

1. I authorize the following person, professional, organization and/or class of individuals to provide the information:

_____

2. Specific person/organization/or class of persons authorized to receive and use the provided information:
Name/Title: _____
Address: _____
City/State:_____ Zip:_____ Telephone:_____

3. Information to be released:
- ❑ Pre-Placement Medical Exam Results
- ❑ Drug Testing Results
- ❑ Driver Qualification Medical Exam Results
- ❑ Fitness for Duty Exam Results
- ❑ Medical Records Relating to one or more of the following benefits:
  - ❑ FMLA ❑ STD ❑ LTD ❑ ADA ❑ Medical/Health Surveillance ❑ Other Benefit
- ❑ All medical records including results of exams, laboratory tests, imaging, etc.
- ❑ All medical information, exam and lab results pursuant to a work-related/occupational injury or illness/workers' compensation claim. Date of injury: _____
- ❑ Other _____

4. Purpose of the request: ❑ To determine fitness-for-duty ❑ Benefit determination ❑ Regulatory compliance
- ❑ At the request of the individual ❑ Determine current medical status and/or return-to-work capability
- ❑ Other_____

5. Right to revoke: I understand I have the right to revoke this authorization at any time by notifying ABC Corporation in writing at: _____ to the attention of _____ . I understand that the revocation is only effective after it is received and logged by ABC Corporation and that any use or disclosure made prior to the revocation under this authorization will not be affected by the revocation. I further understand that my revocation of this authorization may affect my ability to receive ABC Corporation benefits affected by this revocation (Optional Statement in Italics)

6. I understand that after this information is disclosed, federal law may not protect it, and the recipient may redisclose it.

7. I understand that my initial and continued employment and position are subject to my agreement to this authorization and any additional authorization ABC Corporation requests. (Optional statement)

8. I understand I am entitled to a copy of this authorization.
I am requesting a copy of this authorization ❑ *Yes* ❑ *No - If Yes, I have received a copy*_____ *(initial)*

9. I understand this authorization will expire when my employment with ABC Corporation terminates.

Signature of Employee _____ Date _____

Personal Representative Section:
If a personal representative executes this form, that representative warrants that he or she has authorization to sign this form on the basis of _____

Source: Sample HIPAA Compliant Authorization, DVDiBenedetto & Associates Ltd./DVD Associates LLC.