

**PACIFIC UNIVERSITY HUMAN RESOURCES DEPARTMENT
AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION**

I understand that the Pacific University Human Resources Department may need to use and disclose my health information for purposes of treatment, payment, health care operations or other reasons permitted by law.

I understand that my health information may include information both created and received by the Department, may be in the form of written, electronic or verbal communication and may include information about my health history, health status, symptoms, examinations, test results, diagnoses, treatments, procedures, prescriptions and similar types of health related information.

Part 1. INDIVIDUAL'S INFORMATION

Name:		Date of Birth:	
Address:		City:	
State:	Zip Code:	Phone #:	

Part 2. INFORMATION ABOUT THE USE OR DISCLOSURE

I understand that this authorization is voluntary and that I may revoke it at any time by submitting my revocation in writing to the Pacific University Human Resources Department.

I, the undersigned individual, hereby authorize Pacific University to release to the person listed below all information, including medical records, relating to the medical, physical, behavioral and mental condition, treatment, claims, billing and expenses of the individual identified in Part 1, which are held by you. I also authorize the release of documents related to application or authorization for medical services, case management records, utilization management records, and care coordination documents.

Release my Protected Health Information to:

Name: _____ Phone #: _____
 Address: _____
 City: _____ State: _____ Zip Code: _____

Purpose for Disclosure:

- Insurance or Eligibility/Benefits
- Legal Investigation or Action
- At the request of the Individual
- Other (specify): _____

Expiration date of Authorization: _____ (indicate date, or an event relating to you or to the purpose of the authorization).

Part 3. IMPORTANT INFORMATION ABOUT YOUR RIGHTS

I have read and understood the following statements about my rights:

- ◆ I may revoke this authorization at any time prior to its expiration date by notifying the Pacific University Athletic Training Department in writing, but the revocation will not have any affect on any actions taken before the revocation was received.
- ◆ I may see and copy the information described on this form if I ask for it.
- ◆ I am not required to sign this form to receive health benefits (treatment, payment, enrollment)
- ◆ The information that is used or disclosed pursuant to this authorization may be re-disclosed by the receiving entity.

Part 4. SIGNATURE

I hereby authorize the Pacific University Human Resource Department to use or disclosed my health information as described in Part 2.

Signature of individual or legal representative	Date
Printed name of individual or legal representative	Representative's relationship to individual
Signature of witness	Date

