Human Resources Benefits Department
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Employee Authorization to Allow Sunnyside to Disclose Protected Health Information (PHI)

Authorization for Use of Disclosure of Protected Health Information Required by the Health Insurance Portability and Accountability Act

Employee Name: _____

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

This Authorization is to remain in full force until my employer receives written notification from me of its revocation, or it will expire on date _____.

If date is left blank the Authorization will remain in effect for 10 days from the date of signature below.

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

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 the 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)

_____

_____

Employee Signature: _____ Date:_____

First and Last Name Printed: _____