AUTHORIZATION FOR DISCLOSURE OF PROTECTED HEALTH INFORMATION

Printed Name | Date of Birth | Last 4 Digits of Social Security No.

Full Address | Telephone No.

I hereby authorize the following healthcare provider(s):

NAME OF HEALTH CARE PROVIDER

Address

Phone # Fax #

NAME OF HEALTH CARE PROVIDER

Address

Phone # Fax #

NAME OF HEALTH CARE PROVIDER

Address

Phone # Fax #

To disclose my Protected Health Information, as described in this form, to:

East Tennessee State University – Human Resources
Name of Health Care Provider/Plan/Other

P.O.Box 70564
Address

Johnson City, TN 37614
City, State, Zip Code

423-439-4457
Phone #

If the person/entity listed above is not a health care provider, health plan or other person/entity who must follow privacy laws the health information disclosed under this Authorization may no longer be protected and may be re-disclosed without obtaining your permission.

Protected Health Information to be disclosed:

Diagnosis of relevant conditions and treatment plan; patient's ability to perform work; recommendations, medical history, reports and correspondence. This request is for relevant medical and mental/behavioral health information reasonably related to the individual's request for medical leave.

Purpose for disclosure of Protected Health Information:

Determination and evaluation of eligibility for medical leave.

You are not required to sign this Authorization. If you choose not to sign this Authorization, it will not affect your treatment, payment, enrollment or eligibility for benefits. However, if you choose not to sign this form ETSU may be unable to determine your eligibility for medical leave. Once you sign this Authorization form you may change your mind and revoke it at any time. You must notify us in writing if you wish to revoke this Authorization. Your revocation will not be effective in relation to information already disclosed under this Authorization. Please notify Human Resources at the address listed above if you wish to revoke this Authorization.

Expiration: This Authorization will expire once the need for medical leave no longer exists.

By signing below, you confirm you had the opportunity to read and understand this Authorization and that it accurately reflects your wishes.

Signature of Employee | Date

**If signed by someone other than the individual, proof of legal authority to act on the individual's behalf must be provided.*