

**UNIVERSITY OF LOUISVILLE
EMPLOYEE HEALTH INSURANCE PLAN**

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

_____ Form received by		_____ Date	
1. Your name	2. Whose health information are you requesting? <input type="checkbox"/> Self <input type="checkbox"/> Other (please give that person's name)		
3. If you did not check self in Box 2, please describe your legal authority to act on that person's behalf. <input type="checkbox"/> parent <input type="checkbox"/> legal representative	If you are not the insured U of L employee please provide the following information: Employee's name: _____ Employee's Health Plan ID number: _____ Employee's Date of Birth: _____		
Mail address for records			
_____ Street address	_____ City	_____ State	_____ Zip
I hereby authorize Employee Group Health Insurance Plan ("Plan") or its designee to use and/or share the health information as described in section A – D below.			

Section A: Health Information to be used and/or shared.

Specify the health information you wish use to use or share. Please indicate a specific time period unless your request applies to your entire record.

Any and all records related to Claim Number _____ including any psychotherapy notes
 Any and all records related to Claim Number _____ excluding any psychotherapy notes
 Any and all records for the period of _____ to _____ including any psychotherapy notes
 Any and all records for the period of _____ to _____ excluding any psychotherapy notes
 All records maintained by the Group Health Plan and its designees _____

Section B: Person(s) Authorized to Receive Health Information

Please release my health information, described in section A, to the follow individual(s) and/or company(ies).

Section C: Purpose for which your health Information will be Used or Shared.

Please indicate each reason that the health information described in Section A is being used or shared. Select all boxes that apply:

To facilitate the resolution of a disputed claim
 As part of my application for leave under the Family Medical Leave Act (FMLA) or state family leave laws
 For disability coverage determination
 At my request
 Other (please explain) _____

Section D: Expiration of this Authorization

I understand that unless I specify otherwise this authorization will expire 1 year from the date of my signature below. I wish to have this authorization expire on a different date:

- On the following date _____
- After _____ days or after _____ months
- Upon my disenrollment from the University of Louisville’s group health plan
- Upon my return from FMLA
- Other (please specify) _____

Section E: Specific rights and understandings

I understand

- I may revoke this authorization at any time by submitting a written notice of revocation to:
**University of Louisville Human Resources Department
Employee Benefits,
1980 Authur St, Suite 100,
Louisville, KY 40208.**
- The revocation of this authorization will not apply to my health information that was already used or shared prior to the revocation.
- Any information that is shared with other persons or companies, the information may re-disclose and the information may not longer be protected by federal privacy regulations and laws.
- If I am a current Plan member, my treatment, payment, enrollment or eligibility for benefits will not be conditioned on my signing this authorization.
- If I am not currently enrolled in the Plan and this authorization was requested so the Plan can make an eligibility or enrollment determination or an underwriting or risk rating determination, my eligibility for enrollment or benefits may be effected if I fail to sign this form.
- I am entitled to a copy of this authorization

Signature*

Date

***This must be the individual who is the subject of the health information requested unless the person is a legal representative of the individual who is the subject of the health information**

The individual who is the subject of the health information requested is unable to sign due to:

Legal representative

Date