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?  □ Self  □ 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.  □ parent  □ 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

□ Any and all records related to Claim Number

□ Any and all records for the period of to

□ Any and all records for the period of to

including any psychotherapy notes excluding any psychotherapy notes

including any psychotherapy notes 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,

215 Central Ave. Suite 205, 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