UNIVERSITY OF HARTFORD

Human Resources Development
200 Bloomfield Avenue
West Hartford, CT 06117
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Individual Authorization for Release of Information

Note: This form cannot be used for the authorization to release psychotherapy notes.

Authorization Form to Use and/or Disclose Protected Health Information (PHI)

PLEASE READ THIS DOCUMENT CAREFULLY

This authorization form permits the University of Hartford Welfare Benefit Plan (the Plan) to use and/or disclose my PHI as noted below. The Plan will not condition my enrollment, eligibility or payment of benefits as a result of this signed authorization. I understand that I retain the right to revoke this authorization at any time by sending a written revocation to the Privacy Officer at the address shown below. My revocation will not apply, however, to uses and/or disclosures the Plan has already made in reliance on this authorization. Additionally, I retain the right to inspect and/or copy the PHI I have authorized to be used and/or disclosed by contacting the Privacy Officer at the address shown below.

I authorize the Plan to use and/or disclose the following PHI (describe information below)**:**

I authorize the Plan to use and/or disclose the PHI identified above to the following entity or persons (describe to whom PHI will be released below)**:**

I authorize the Plan to use and/or disclose the PHI identified above for the following purpose or purposes (describe the purpose of the use and/or disclosure and whether it is at the request of the participant or beneficiary)**:**

This authorization is valid until:

Please provide the following information if you are a representative of a participant or beneficiary enrolled in the Plan:

1. Name of participant or beneficiary:
2. Describe relationship with individual or nature of authority:
3. Your address:
4. Your home telephone number:
5. Your work telephone number:

Please note that you must provide valid and current proof of your legal relationship as a personal representative.

Please Read Carefully and Sign

I understand that the Plan will use and/or disclose my PHI as described above until this authorization expires. I understand that I will receive a copy of this signed authorization for my records. I also understand that any PHI released pursuant to this authorization may be re-disclosed by the recipient, and that any such re-disclosure may not be protected by law.

_____ _____

Print Name Social Security Number

_____ _____

Signature Phone Number or Extension

Privacy Officer
CC327
University of Hartford
200 Bloomfield Avenue
West Hartford, CT 06117
(860)768-4209