

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

I, _____, hereby authorize the use or disclosure of my health information as described in this authorization.

- (1) Specific person/organization authorized to provide the information:

- (2) Specific person/organization authorized to receive and use the information:

- (3) Specific and meaningful description of the information:

- (4) Purpose of the request:
(Please state the purpose of the request below. If you do not wish to state a purpose, please state "At the request of the individual.")

- (5) *Right to Revoke*: I understand that I have the right to revoke this authorization at any time by notifying _____ in writing at _____
I understand that the revocation is only effective after it is received and logged by III. I understand that any use or disclosure made prior to the revocation under this authorization will not be affected by a revocation.

- (6) I understand that after this information is disclosed, federal law might not protect it and the recipient might redisclose it.

- (7) I understand that my initial and continued employment and position are subject to my agreement to this authorization, and any additional authorization III requests.

- (8) I understand that I am entitled to receive a copy of this authorization.

- (9) I understand that this authorization will expire when my employment with III terminates.

Signature of Employee _____ Date _____

Personal Representatives section

If a Personal Representative executes this form, that Representative warrants that he or she has authority to sign this form on the basis of

_____.