

**Authorization For Use Or Disclosure
Protected Health Information (Health Plan)**

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) protects certain health information (PHI) that is related to the health plans sponsored by UST. In order for UST personnel or others to work with you when PHI is involved, the following form needs to be completed.

Employee Name (print): _____
Whose PHI is being discussed: _____
Relationship to Employee: _____
Date Authorization is Granted: _____

I hereby authorize the use and disclosure of my health information as indicated below. I understand that this authorization is voluntary and that I may revoke this authorization at any time except to the extent that action has been taken in reliance on this authorization. I also understand that if the individual or organization authorized to receive this information is not required to comply with current privacy regulations, my health information may be disclosed to others and no longer be protected by current state and federal privacy regulations.

I authorize the use and/or disclosure of the following PHI:
 Complete or partial medical records
 Complete or partial dental records
 Billing statements
 Other: _____

I authorize the information to be released to:
 UST Benefit Team
 My UST HR Partner
 Other: Name: _____
Address: _____
Phone: _____
Fax: _____

The information I have authorized to be released may be used for the purpose of:
 Claims/Payment
 Eligibility/Coverage
 Other: _____

This authorization is valid for one (1) year after the date it is signed or upon completion of the use of the information for the purpose it was intended, unless an earlier expiration date is indicated here: _____.

I understand that the individual, organization, or entity receiving my health information may receive financial or in-kind compensation in exchange for using or disclosing the information described above.

I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment or payment or my eligibility for benefits.

I understand that I may inspect and copy any information used or disclosed under this authorization. I understand that a fee may be charged for such copying services.

I hereby release the health plan, its employees, officers, and health care professionals from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized herein.

I understand that I may revoke this request at anytime by providing the University of St. Thomas with my written notice of such revocation.

Date: _____ Signature of Employee: _____

Print Name: _____

Date: _____ Signature of Individual Being Discussed, if not Employee: (not required if dependent child)

Print Name of Individual: _____

Relationship to Individual and basis upon which can sign: _____

Date: _____ Signature of Witness: _____

Print Name of Witness: _____