Authorization For Release of Protected Health Information

I hereby authorize any Health Care Provider, Physician or any member or employee of its office or association, who has examined or treated me, as well as any hospital or treatment facility in which I have been a patient, to disclose and release complete and legible copies of any and all information concerning my physical or psychiatric condition, care and treatment, to my employer and/or my employer's duly authorized representative, and or their attorneys.

A copy of this Authorization for Release, which contains my signature, shall be considered as effective and valid as the original and shall be honored by those to whom it is sent or provided.

Employee Signature:_____ Date:_____

Printed Name of Employee:_____

Date of Birth:_____ Last 4 of SSN:_____

Address:_____

Home Phone Number:_____ Cell Phone Number:_____

HUMAN RESOURCES DEPARTMENT
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