UNIVERSITY OF NEBRASKA
FULLY-INSURED GROUP HEALTH PLAN
AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

_____ _____
Employee Name **University ID Number**

INDIVIDUAL AUTHORIZING RELEASE OF PHI

COVERED/INSURED PERSON'S NAME_____ **D.O.B.**_____

ADDRESS_____ **PHONE #**_____ **S.S. #**_ _ _ - _ _ - _ _ _ _

I hereby authorize the disclosing party listed below to use and/or disclose my Protected Health Information (PHI) as follows:

INDIVIDUAL AUTHORIZED TO RECEIVE PHI

1. **DISCLOSING PARTY:**_____

2. **DISCLOSE TO**:_____
   Recipient Name Address Phone Number

   _____
   Recipient Name Address Phone Number

3. **THIS AUTHORIZATION IS VALID UNTIL**: _____

4. **DISCLOSE THE FOLLOWING HEALTH INFORMATION**:
   - All health information requested by the recipient related to the following claim or episode of care: _____
   - Specify the information about a particular admission, treatment or episode of care:_____
     _____

5. **WHAT OTHER LIMITATIONS APPLY**? If none, write "none:" _____

6. **PURPOSE**: If the authorization was requested by the Group Health Plan, what is the purpose of the disclosure?
   _____

TERMS:

1. Refusal to sign this authorization will not affect your ability to enroll in or receive benefits under the Plan.
2. Health information to be disclosed under this authorization may be subject to re-disclosure by the recipient and no longer protected by State or federal law.
3. You may revoke this authorization at any time by giving written notice to your Campus Benefits Manager, UNL: 472-2600, UNMC: 559-4340, UNO: 554-3660; UNK: 865-8522, UNCA: 472-7162. Your revocation will not be effective to the extent action has already been taken in reliance on your authorization.
4. A photocopy or exact reproduction of this signed authorization will have the same force and effect as the original.
5. A statement of the Personal Representative authority to act on behalf of the covered person must be provided. Approved documentation includes the Power of Attorney authorization or letter of guardianship appointing you as Personal Representative.

_____ _____
Signature of Covered Person Authorizing Release of PHI Date

OR

_____ _____
Signature of Personal Representative Authorizing Release of PHI Date

_____ _____
Relationship of Personal Representative to Covered Person Date