Human Resources

HIPAA Authorization for Use and Disclosure of Protected Health Information

(FMLA)

1. I hereby authorize _____ ("Provider") to use and/or disclose the protected health information about me described below ("PHI") to the University of Delaware.
2. The PHI that may be used and/or disclosed is all PHI required in the attached Certification of Health Care Provider form.
3. The PHI may be used and/or disclosed to assist the University of Delaware in administering my FMLA leave.
4. This authorization shall remain in effect for one year from the date of this authorization written below.
5. I understand that I have the right to revoke this authorization, in writing, at any time, except to the extent that Provider has acted in reliance upon it, by sending written notification to:

   _____

   _____

   _____

   (Provider Name & Address)

6. I understand that signing this authorization is completely voluntary and that I have the right to refuse to sign this authorization. I understand that the Provider may not condition my treatment, payment, enrollment or eligibility for benefits on my signing this authorization.
7. I understand that PHI used or disclosed pursuant to this authorization may be redisclosed by the recipient and its confidentiality may no longer be protected by federal or state law.
8. I understand that the PHI disclosed may include information pertaining to the treatment of drug and alcohol abuse, mental illness, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV), sexually transmitted diseases, tuberculosis, hepatitis C or genetics. **If you do not wish for this specific information to be disclosed, please describe the category(ies) of information to be excluded:**

   _____

   _____

_____ _____

(Name) (Date)

_____ _____

(Signature) (Relationship to Patient)