

# Northwestern Health Sciences University Health Plan Authorization to Release Protected Health Information

Please complete this Authorization form completely. The authorization will not be valid unless all blanks are completed. If you have any questions, contact the Human Resources offices at Northwestern Health Sciences University, 2501 West 84<sup>th</sup> St., Bloomington, MN 55431.

## I. AUTHORIZATION

I authorize the use or disclosure of my Protected Health Information (PHI) as explained below.

*I understand that this authorization is voluntary and that I may cancel it at any time by submitting my cancellation in writing to the person/company providing the information.*

Participant Name \_\_\_\_\_ SS # \_\_\_\_\_ Birthdate \_\_\_\_\_

I authorize \_\_\_\_\_  
Name of Person(s) or Organization(s) authorized to release information to a third party (include name and complete address)

to disclose the information described below to \_\_\_\_\_  
Name of Person(s) or Organization(s) who will receive the disclosed information (include name and complete address)

Specific description of the information to be used or disclosed (including dates): \_\_\_\_\_  
\_\_\_\_\_

The information will be used to (be as specific as possible) \_\_\_\_\_  
\_\_\_\_\_

This authorization is valid for one year after the date it is signed, unless an earlier expiration date is listed here  
\_\_\_\_\_

## II. IMPORTANT INFORMATION ABOUT YOUR RIGHTS

I have read and understood the following statements about my rights:

1. I may cancel this authorization at any time prior to its expiration date by notifying the providing organization in writing. I understand that the cancellation will NOT apply to any actions the organization took before it received the cancellation.
2. I may see and copy the information described on this form if I request it.
3. I am not required to sign this form to receive my health care benefits (enrollment, treatment or payment).
4. The information that is used or disclosed as a result of this authorization may be re-disclosed by the receiving person/organization.

## III. SIGNATURE OF PARTICIPANT OR PARTICIPANT'S PERSONAL REPRESENTATIVE

By my signature below, I certify that I have reviewed the above information and have or will receive a signed copy of this designation/authorization form for my records. I also understand that, after reviewing the above information, I have the right to refuse to sign this designation/authorization.

\_\_\_\_\_  
Signature of Participant or Participant's Personal Representative  
(Form MUST be completed BEFORE it is signed)

\_\_\_\_\_  
Date

Name of Personal Representative \_\_\_\_\_

Description of Personal Representative's Authority/Relationship \_\_\_\_\_