I. Information About the Use or Disclosure

I hereby authorize the use or disclosure of my individually identifiable health information. I understand that this authorization is voluntary and that I may revoke it at any time by submitting my revocation in writing to Southeast Missouri State University providing the information.

Name: _______________________________  ID Number: _______________________

Persons/organizations authorized to provide the information: _______________________________
________________________________________________________________________________

Persons/organizations authorized to receive the information: _______________________________
________________________________________________________________________________

Specific description of information to be used or disclosed (including date(s)): __________________
________________________________________________________________________________

Specific purpose of the disclosure: ____________________________________________________
________________________________________________________________________________

I hereby request that I receive communications of my Protected Health Information by the following means of contact: _________________________________________________________________

This authorization will expire _________________________________________________________
(Indicate date, or an event relating to you personally or to the purpose of the authorization).

II. Important Information About Your Rights

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

• I may revoke this authorization at any time prior to its expiration date by notifying the University in writing, but the revocation will not have any affect on any actions taken before it received the revocation.
• I may see and copy the information described on this form requested.
• I am not required to sign this form to receive my health care benefits.
• The information that is used or disclosed pursuant to this authorization may be redisclosed by Southeast Missouri State University. I have the right to seek assurance from the above-named persons/organizations authorized to receive the information that they will not redisclose the information to any other party without my further authorization.

III. Signature of Employee or Employee’s Representative  (Form MUST be completed before signing.)

Signature of employee or employee’s representative: ___________________________  Date: ___________________________

Employee’s personal representative: ___________________________  Relationship: __________

*YOU MAY REFUSE TO SIGN THIS AUTHORIZATION*

You may not use this form to release information for treatment or payment except when the information to be released is psychotherapy notes or certain research information.