AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

Section 1: Member Information

Patient Name:_____ Date of Birth: _____

Name of Employee:_____ Relationship of Patient to Employee:_____

Identification Number:_____ Telephone: _____

Address: _____

Section 2: Authorization

I, _____, authorize Loyola University New Orleans Employee Benefit Plan to disclose to the authorized person(s) listed in Section 6 my "Protected Health Information," more specifically described as follows:

_____

_____

This includes any medical or mental health information relating to the treatment for alcohol or drug abuse, sexually transmitted diseases, and/or HIV or AIDS. This authorization is not an authorization for use of disclosure of Psychotherapy Notes.

The purpose of providing this information to the authorized person(s) listed below is to:

- ☐ Satisfy an inquiry related to health benefits.
- ☐ Obtain a determination as to whether employee can perform essential functions of job and conclusions related to a fitness-for-work exam.
- ☐ Obtain results from drug testing for employment-related reasons.
- ☐ Respond to a request for an accommodation under the American with Disabilities Act.
- ☐ Respond to a request for a leave of absence under the Family and Medical Leave Act.
- ☐ Comply with a request of the individual.
- ☐ Other: _____

Section 3: Revocation

I understand that I have the right to revoke this authorization at any time by notifying Donna Rochon, Privacy Officer for the Loyola University New Orleans Employee Benefit Plan, Human Resources Department, Loyola University New Orleans, 6363 St. Charles Avenue, Campus Box 16, New Orleans, LA 70118, 504.864.7272 (phone), 504.864.7100 (fax). I understand that the revocation is only effective beginning two days after receipt by Loyola University New Orleans. I understand that any use or disclosure made prior to two days after receipt of revocation under this authorization will not be affected by a revocation.

Section 4: Re-disclosure

I understand that after the above information is disclosed, federal law might not protect it, and the recipient might re-disclose it. I further understand that I am entitled to receive a copy of this authorization.

Section 5: Expiration (check only one box)

☐ This authorization is valid from the date of my signature until the earlier of the following dates: (1) the date I am (or my spouse or parent is) no longer an employee of Loyola University New Orleans; (2) the date written notice of revocation of this authorization is received and logged by Loyola University New Orleans; or (3) the date ending 12 months following execution of this Authorization.

Or

☐ The authorization shall terminate on (specify date):_____

Section 6: Authorized Person(s)
Please provide the information below that is authorized to receive your protected health information identified above. You may list up to two (2) authorized persons on this form. Please Print.

Name: _____ Name: _____

Organization: _____ Organization:_____

Address:_____Address:_____

Telephone: _____Telephone: _____

Relationship to Patient: _____Relationship to Patient: _____

Section 7: Signature
I understand that, by signing this form, I am confirming my authorization that the Loyola University New Orleans Employee Benefit Plan may disclose the protected health information described in this form to the authorized person(s) named above. I further understand that I am not required to sign this form to receive my health care benefits (enrollment, treatment, or payment).

Patient Signature:_____

If a personal representative signs this revocation on behalf of the Individual, complete the following:

Personal Representative's Name: _____

Relationship to Individual: _____

Check One:

☐ **Health Plan has a copy of my authorizing documentation as a personal representative.**
☐ **Attached is a copy of my documentation as a personal representative.**

Please mail or fax the completed Authorization Form to: Donna Rochon, Privacy Officer for the Loyola University New Orleans Employee Benefit Plan, Human Resources Department, Loyola University New Orleans, 6363 St. Charles Avenue, Campus Box 16, New Orleans, LA 70118, 504.864.7272 (phone), 504.864.7100 (fax).