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

__________________________   __________________________
Employee Name   **Personnel 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.

____   ____________________
Signature of Individual Authorizing Release of PHI   Date