

**UNIVERSITY OF NEBRASKA
SELF-FUNDED 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 Group Health Plans sponsored by the University of Nebraska to use and/or disclose my Protected Health Information (PHI) as follows:

INDIVIDUAL AUTHORIZED TO RECEIVE PHI

1. **DISCLOSE TO:**
- | | | |
|----------------|---------|--------------|
| _____ | _____ | _____ |
| Recipient Name | Address | Phone Number |
| _____ | | |
| Recipient Name | Address | Phone Number |

2. **THIS AUTHORIZATION IS VALID UNTIL:** _____

3. **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. _____

4. **WHAT OTHER LIMITATIONS APPLY?** If none, write "none:" _____

5. **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