Employer HIPAA Release Authorization

Employee Name:
Employee Date of Birth:
Employee Address:
Authorization
I hereby authorize the release of my health information to:
Employer Name:
Employer Address:
Purpose of Disclosure:
Specific Information to be Disclosed:
Expiration Date or Event:
Expiration bate of Event.
Additional Limitations (if any):
Additional Entitletions (in any).
Employee Signature:
Date: