SALT LAKE COUNTY

Human Resources

AUTHORIZATION TO DISCLOSE HEALTH INFORMATION

Print Form

Salt Lake County Use Only - (HIPPA)

Employee Name: _____ SSN: _____ Date of Birth: _____

I _____ hereby authorize my health care provider to disclose specific health information from my records to: _____

(Person(s) and/or Organization(s) Receiving the Information)

The specific health information authorized for disclosure is: _____

The purpose of the disclosure is: _____

This authorization will expire on the following date, event, or condition: _____

I understand that if I fail to specify an expiration date or condition, this authorization is valid for the period of time needed to fulfill its purpose. I may not be eligible for the program I am applying for if the date I set occurs before the completed information is received by my employer. I also understand that I may revoke this authorization at any time, by sending written notification to the Salt Lake County Human Resources Division.

Employer use of Disclosure:

- ☐ Americans with Disabilities Act (ADA)
- ☐ Return to Work Non Workers' Compensation
- ☐ Fitness for Duty (FFD)
- ☐ Employee Assistance
- ☐ Other, Please Specify

I understand that I may refuse to sign this Authorization. I also understand that my health care and the payment for my health care will not be affected if I do not sign this form. I further understand I am not required to sign this form to receive my health care benefits (enrollment, treatment or payment, etc). I understand that I may see and copy the information described on this form if I ask for it, and that I will receive a copy of this form after I sign it. I understand I may not be eligible for the program I am applying for (e.g. coverage under the ADA etc.) if I do not sign this form.

I understand the information that is used or disclosed pursuant to this authorization may be re-disclosed by the receiving entity. I have the right to ask that this information not be disclosed to any party without further authorization. I understand I may not be eligible for the program I am applying for (e.g. ADA, etc.) if I do not allow disclosure or redisclosure.

_____

Signature of employee or Personal Representative Date

If signed by a Personal Representative, relationship to the employee: _____

Return ADA forms to County ADA Coordinator, N4-700