UNIVERSITY OF NOTRE DAME DU LAC GROUP BENEFITS PLAN  
Authorization for Use and Disclosure of Protected Health Information

You have the right to authorize another individual and/or organization to provide or receive your protected health information. This form is to be used for medical information only. To be valid, questions 1-7 below must be completed.

1. Please print your first and last name: _________________________________________________

2. Please print your email address:______________________________________________________

3. Provide the name of the person(s)/organization(s) that you authorize to provide or receive medical information for or about you (for example: the name of your medical plan);  
_________________________________________________________________________________

4. Provide the name of the person(s) and their relationship or the organization(s) that you authorize to receive medical information for or about you:  
_________________________________________________________________________________

5. Provide a purpose and specific description of the medical information that is to be used or disclosed. (for example: at the request of the individual, and to discuss all claim information for me) 
Purpose: ________________________________________________________________________  
Description: ____________________________________________________________________ 

6. Provide a date when this authorization will expire (indicate a date, or an event that relates to you or to the purpose of the use/disclosure, for example: at the end of a specific year or no expiration date)  
_________________________________________________________________________________

If no expiration date is given, this authorization will expire one year after it is signed below

- YOUR RIGHTS -
This authorization is voluntary and I understand that I may revoke this authorization at any time prior to its expiration date by notifying HR Services in the Office of Human Resources in writing, but the revocation will not have any effect on any actions taken in reliance of this Authorization or relating to the use or disclosure of the protected health information that the University of Notre Dame du Lac Group Benefits Plan took before it received the revocation.

I may inspect and copy the protected health information described on this form if I ask for it.

I am not required to sign this authorization to become eligible or to receive my health care benefits (enrollment, treatment, or payment).

The information that is used or disclosed in accordance with this authorization may be redisclosed by the receiving entity and may no longer be protected by federal or state privacy laws.

7. Your Signature or Your Representative's Signature*  

Signature ___________________________________________ Date __________________________

* If this authorization is not signed by you but is signed by your personal representative, complete the following steps: Print their name, relationship to you and their legal authority for status as representative (for example: Mary Smith, child, power of attorney):

Printed Name ___________________________________________ Relationship ___________________________ Legal Authority ___________________________

Please keep a copy and return the completed original form to:  
HR Services Manager, Office of Human Resources, 200 Grace Hall

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