

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

PART A: INFORMATION ABOUT THE USE OR DISCLOSURE OF MY HEALTH INFORMATION

I authorize the use or disclosure of my individually identifiable health information as described below. I understand that this authorization is voluntary and I have the right to revoke it at any time by submitting a written notification to the person/entity I authorize to disclose the information in Part A (2).

Individual's Name:

Social Security Number:

1. Persons/organizations authorized to disclose the information (e.g. your health care provider who will provide Smith College with relevant health information regarding your ADA accommodation request): _____
2. Persons/organizations authorized to receive the information: Smith College Human Resources and others responsible for managing the Smith College ADA accommodation request process.
3. Specific description of the information to be used or disclosed: health information related to employee's job-related accommodation request.
4. Specific purpose of disclosure: to evaluate ADA accommodation request.
5. This authorization will expire upon completion of the ADA accommodation process.

PART B: IMPORTANT INFORMATION ABOUT YOUR RIGHTS

I have read and understand the following statements about my rights:

- I understand that I am not required to sign this form. Moreover, I am not required to sign this form to receive my health care benefits (enrollment, treatment or payment) or health care from a health care provider (except where the sole reason for the treatment is to create information to provide to a third party such as a fitness for duty exam). However, I understand that if I refuse to sign this authorization, there may be employment-related consequences, including a denial of any request I have made under the Americans with Disabilities Act ("ADA").
- I may revoke this authorization at any time prior to its expiration date by submitting a written notification to the person/entity identified in item 2 above. I am aware that the revocation will not have any effect on information already used or disclosed before receiving my revocation.
- I may see and copy the information described on this form if I ask.
- I understand that once my personally identifiable health information is disclosed to the individuals or entities listed above, it is no longer protected by the privacy requirements in HIPAA, and they may re-disclose my health information to any other party for the purpose specified in Part B(5), above.

PART C: SIGNATURE OF EMPLOYEE

Signature of Employee

(Form **MUST** be completed before signing)

Date