

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

I _____ hereby authorize the use or disclosure of my health information as described in this authorization.

(1) Specific person/organization (or class or persons) authorized to **provide** the information (e.g., Zimbrick, Inc.'s Human Resource Department).

(2) Specific person/organization (or class of persons) authorized to **receive and use** the information (e.g., name of person or organization you wish to receive the information):

(3) Specific and meaningful description of the information to be used or disclosed:

(4) Purpose of the request (if you do not wish to state a purpose, please write "At the request of the individual.")

(5) **Right to revoke:** I understand that I have the right to revoke this authorization at any time by notifying Zimbrick, Inc.'s HIPAA Privacy Contact Person(s) in writing at Zimbrick, Inc., 1601 W. Beltline Hwy., Madison, WI 53713; (call 1-608-271-1602 ext .311) and ask for the HIPAA Privacy Contact Person with any questions. I understand that the revocation is only effective after it is received and logged by Zimbrick, Inc. I understand that any use or disclosure made prior to the revocation under this authorization will not be affected by a revocation.

(6) I understand that after this information is disclosed, federal law might not protect it and the recipient might redisclose it.

(7) I understand that my initial and continued employment and position are not subject to this authorization, and any additional authorization Zimbrick, Inc. requests.

(8) I understand that my enrollment in, eligibility for, or payment of benefits may not be conditioned upon whether I sign this authorization, except that enrollment or eligibility for benefits may be conditioned on provision of an authorization prior to my enrollment if: (a) the authorization sought is for the health plan's eligibility or enrollment determinations relating to me or for underwriting or risk rating determinations, and (b) the authorization is not for use or disclosure of psychotherapy notes.

(9) I understand that I am entitled to receive a copy of this authorization.

(10) I understand that this authorization will expire on _____.

Signature

Date

Personal Representative Section:

If a Personal Representative executes this form, that Representative warrants that he or she has authority to sign this form on the basis of:
