HIPAA Authorization for the Release of Health Information
Indiana University Human Resources
Indiana University Health Plans

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This form is used to confirm you, as a member of an Indiana University Health Plan, are giving permission to Indiana University through Human Resources to discuss or disclose Protected Health Information (PHI) to a particular person. This form needs to be completed by filling in all five (5) sections below.

I understand I have the right to authorize another individual to receive my protected health information. I hereby request and authorize Indiana University Human Resources and its employees to release my protected health information, including, but not limited to, premium information, eligibility status, claims history, identification of treating providers, diagnoses, procedures and demographic information to the person named below.

1. My Contact Information			
Name:		Date of Birth (mm/dd/yy):	
Address:	City:	State:	Zip:
10-Digit University ID:	Phone:		

2. The person to whom IU may release PHI			
Name:		Date of Birth (mm/dd/yy):	
Address:	City:	State:	Zip:
Relationship:	Phone:		

3. I understand this release may include information related to treatment which may include the categories listed below. I have the right to specifically request these records NOT be released. Please check the category of records, if any, you wish to NOT be released.	
❑ Mental Health Records	❑ Sexually transmitted diseases
❑ Psychotherapy Notes	❑ Alcohol/substance abuse
❑ HIV (AIDS)	❑ Sickle Cell Anemia
❑ Other:	

4. Specific information to be disclosed. (e.g. "All health information" or "MRI performed on 1/4/2018"):

5. This authorization will expire (select one):		
❑ Sixty (60) days	❑ One (1) year	❑ One (1) year following the termination of my enrollment

6. Authorization	
I understand this authorization is voluntary and I may revoke or cancel this authorization at any time prior to its expiration date. If I choose to cancel this authorization, I must notify in writing Indiana University Human Resources at the address listed at the top of this form. The cancellation of this release will not affect any action that has been taken or information already released before the Plan actually received my request to cancel. I understand that if the person named in this authorization may not be a health care provider, the information may no longer be protected under federal and state privacy laws and may be further disclosed without my permission. I understand that Indiana University will not deny treatment, payment, enrollment or eligibility for benefits based upon whether I sign this authorization. I also understand I may inspect or have a copy of any information released under this authorization.	
Signature:	Date:

Please mail, email or fax a signed copy of this form to the contact listed at the top of this form.