

# AUTHORIZATION TO RELEASE INFORMATION

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I, \_\_\_\_\_, (full legal name of employee)

hereby authorize \_\_\_\_\_ RICHMOND BURTON CHSD 157 to release to

\_\_\_\_\_  
(individual or organization authorized to receive the medical information),

☐ Protected Health Information / ☐ Personnel Information / ☐ Workers Comp information and/or

☐ Other \_\_\_\_\_ from my employee records:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

(Describe generally the information desired to be released.)

I give my permission for this medical information to be used for the following purpose:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

but I do not give permission for any other use or re-disclosure of this information.

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

This authorization shall remain in effect from the date signed below until:

☐ \_\_\_\_\_ (Specify Expiration Date or Event)

☐ NO EXPIRATION DATE

Full name of Employee

\_\_\_\_\_

Signature of Employee or Legal Representative

\_\_\_\_\_

Date of Signature \_\_\_\_\_