AUTHORIZATION TO RELEASE INFORMATION

I, _____, (full legal name of employee)

hereby authorize _____NIPPERSINK SCHOOL DISTRICT 2_____ 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 _____

Created: 5-15-17