



Douglas County, Nebraska

AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION

PATIENT INFORMATION

Employee Name: _____

Previous Name(s): _____

Date of Birth: _____ Last 4 Digits SS#: _____

Address: _____

Primary Phone: _____ Work Phone: _____

AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

I, as an employee of Douglas County, hereby authorize you to furnish the Douglas County Human Resources Department/Civil Service Commission with any and all information with respect to my Family and Medical Leave request. I understand a photocopy, scanned, and/or faxed copy of this Authorization shall be considered as valid and effective as the original.

I may revoke this Authorization at any time by notifying Douglas County in writing of my intent to revoke this Authorization. I also understand that such revocation will not have any effect on any information already utilized by Douglas County before Douglas County receives my written notice of revocation.

Unless revoked earlier, this Authorization will expire one year from the date of signature on this Authorization. I understand that the information disclosed pursuant to this Authorization may be re-disclosed by the recipient without my consent and no longer protected by federal or Nebraska privacy law unless 42 C.F.R., Part 2 or Nebraska privacy law applies. I may inspect and receive a copy (Nebraska law establishes fees for copy charges of medical records) sought to be used or disclosed in the Authorization, as permitted by law. This form is voluntary, and I may refuse to sign it.

Employee Signature

Date

NON-EMPLOYEE AUTHORIZATION

Note: I as a personal representative execute this Authorization and warrant that I have the authority to sign this form on the basis of: _____

Personal Representative Signature

Date