THE UNIVERSITY OF UTAH

Human Resources Division – Benefits Department
250 E 200 S Suite 125, Salt Lake City, Utah 84111
Phone: (801) 581-7447 Fax: (801) 585-7375

AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

Employee Name: _____
Employee ID Number: _____
Employee SS Number: _____

I hereby authorize you to use or disclose my health information as described in this Authorization. I understand this Authorization is voluntary and that I may revoke it at any time by giving a written notice to you.

A specific description of the health information that I am authorizing to be used or disclosed is: Any information necessary to clarify or authenticate the Certification of Health Care Provider you sign in connection with my request for leave under the Family and Medical Leave Act.

The name or other specific identification of the person or organization I am authorizing to receive the health information is: a health care provider representing the University of Utah.

The purpose for which I am authorizing the use and disclosure of the specific health information is with regard to my request for leave under the Family and Medical Leave Act.

This authorization will expire at the end of my FMLA leave. I understand that I may revoke this Authorization at an earlier date by sending a written notification to the Benefits Department. I also understand that my revocation will be effective when received, but that any use or disclosure occurring before receipt of my revocation will not be affected.

Dated: _____

_____
Employee Signature

State of Utah)
)
County of_____)

On this_____day of_____,_____, before me personally appeared _____, proved on the basis of satisfactory evidence to be the person whose name is subscribed to this instrument and acknowledged he/she executed the same. Witness my hand and official seal.

_____
Notary Public