Lucas County

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

I _____ [Employee Name] hereby authorize the use or disclosure of my health information as described in this authorization.

1. Specific person/organization (or class of persons) authorized to provide the information:

   _____

2. (Specific person/organization (or class of persons) authorized to receive and use the information:

   _____

   for the purpose of_____

3. Specific description of the information:

   _____

4. *Right to revoke*: I understand that I have a right to revoke this authorization at any time by notifying Lucas County Risk Management in writing One Government Center, Suite 440, Toledo, OH 43604. I understand that the revocation is only effective after it is received and logged by Lucas County Health Plan. I understand that any use or disclosure made prior to the revocation under this authorization will not be affected by a revocation.

5. I understand that after this information is disclosed, federal law might not protect it and the recipient might re-disclose it.

6. I understand that my written authorization is not required for treatment, payment or health care operation (TPO) purposes.

7. I understand that I am entitled to receive a copy of this authorization.

8. I understand that this authorization will expire one year from date this document was signed or when my employment with Lucas County terminates.

Signature of Employee_____ Date_____

Personal Representatives section
If a Personal Representative executes this form, that Representative warrants that he or she has

authority to sign this form on the basis of: _____