Personnel No.:_____

The School Board of Broward County, Florida
Authorization for Release of Health Information

_____ (**Employee**) authorizes the Benefits Department Staff
(**Please Print Name**)
to use and disclose (release) confidential healthcare information to:

_____ (Specific person[s] and relationship[s]/organization.)
(**Please Print Name[s] and Relationship[s]**)

Type[s] of information to be disclosed/released (please check all that apply):

☐ Medical Issues	☐ Dependent Issues	☐ Status and Rates
☐ Dental Issues	☐ COBRA Issues	☐ Billing Issues
☐ Vision Issues	☐ Retirement Issues	☐ Other:_____

(Please specify precise issues):

_____

Purpose of the release:

☐ By individual's request (Please provide more details on the purpose of this request if so desired):

_____

CONDITIONS:

- The employee agrees to authorize the above-named individuals/organization to access his/her confidential healthcare information only for the purpose listed above.
- Re-disclosures of information by the recipient authorized above may not be protected by the HIPAA privacy rule.
- The employee is voluntarily signing this authorization.
- The employee will receive a copy of the signed authorization.
- The employee reserves the right to refuse to sign this authorization. Enrollment, treatment, payment or eligibility for benefits will not be affected.
- Benefits Department Staff will release only the minimum amount of information necessary to fulfill a request.
- The employee reserves the right to revoke this authorization at any time. This revocation must be in writing and sent to:

The School Board of Broward County, Florida Benefits Department
7770 W. Oakland Park Boulevard
Sunrise, Florida 33351

This authorization will expire three (3) years after the employee's employment with The School Board of Broward County, Florida terminates.

SIGNATURES:

Employee/Personal Representative: _____ Date:_____

Personal Representative's Authority: _____
(Durable Power of Attorney, Designation of Health Care Surrogate, etc.)

Personal Representatives must provide a copy of the document stating they have authority to make health care decisions on behalf of the SBBC employee.

Benefits Dept. Representative:_____Date: _____