

**The University of Scranton**  
**Authorization for Release of Information**

**I. Information About the Use or Disclosure**

I hereby authorize the use or disclosure of my individually identifiable health information as described below. *I understand that this authorization is voluntary and that I may refuse to sign this authorization, and that I may revoke it at any time by submitting my revocation in writing to the entity providing the information.*

Plan Participant name: \_\_\_\_\_ ID Number: \_\_\_\_\_

Persons/organization authorized to provide the information:

\_\_\_\_\_  
\_\_\_\_\_

Persons/organization authorized to receive the information:

\_\_\_\_\_  
\_\_\_\_\_

Specific description of information to be used or disclosed (including date(s)):

\_\_\_\_\_  
\_\_\_\_\_

Specific purpose of the disclosure:

\_\_\_\_\_  
\_\_\_\_\_

Will the health plan or health care provider requesting the authorization receive financial or in-kind compensation in exchange for using or disclosing the health information described above?

No \_\_\_\_\_ Yes (describe) \_\_\_\_\_

This authorization will expire \_\_\_\_\_ (indicate date, or event relating to you personally or to the purpose of the authorization).

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**II. Important Information About Your Rights**

I have read and understood the following statements about my rights:

- I may revoke this authorization at any time prior to its expiration date by notifying the providing organization in writing, but the revocation will not have any effect on any actions that the entity took before it received the revocation.
- I may see and copy the information described on this form if I ask for it.
- I am not required to sign this form to receive my health care benefits (enrollment, treatment, or payment).
- The information that is used or disclosed pursuant to this authorization may be redisclosed by the receiving entity. I have the right to seek assurances from the above-named persons/organizations authorized to receive the information that they will not redisclose the information to any other party without my further authorization.

\_\_\_\_\_  
Plan Participant Signature & Date

\_\_\_\_\_  
Human Resources Representative & Date