AUTHORIZATION FOR HEALTH CARE PROVIDER
TO DISCLOSE PROTECTED HEALTH INFORMATION
TO THE CITY UNIVERSITY OF NEW YORK

At my specific request, I hereby authorize any employees, agents, and subcontractors of _____ (the "Provider") to disclose to Human Resources in the Medgar Evers College Human Resources Department (the "Human Resources Department") the following types of protected health information:

_____

_____

_____

This authorization form will expire on the following date or event: _____

By signing this authorization form, I understand that the protected health information that is disclosed may be redisclosed if the Human Resources Department is not required by law to protect the privacy of the information and such information is no longer protected by federal health information privacy regulations.

I understand that my health care, the payment of my health care, and my health benefits will not be affected if I do not sign this form.

I also understand that I may revoke this authorization in writing, except to the extent that the Provider has taken action based on this authorization. I understand that I should contact both the Provider at_____ and the Human Resources Department at 1650 Bedford Avenue, Brooklyn, NY 11225 if I wish to revoke this authorization.

_____
Signature of Employee or Personal Representative

_____
Print Name of Employee or Personal Representative

_____
Date

_____
Description of Personal Representative's Authority