HIPAA COMPLIANT
AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION AND PROTECTED HEALTH INFORMATION

PATIENT NAME: _____
DOB:_____

The undersigned patient or patient representative does hereby certify as follows:

1. The named medical provider(s), _____ _____ ("Providers") is hereby authorized and directed to release to Case Western Reserve University's Office of Equity ("CWRU/Equity") any and all information of any kind or description which they request, including, without limitation, copies of all records or other medical information concerning any services rendered to me or arranged by the Providers with regard to consultation, treatment, care, hospitalization, or scientific analysis rendered to me for the injury, disease or illness ("Health Information") giving rise to my potential need for accommodations in the workplace.

2. I ask the named medical provider to furnish all requested Medical Information directly to CWRU/Equity. I understand that any agreements I have made to restrict my Protected Health Information ("PHI") do not apply to this authorization and I instruct the named medical provider that they are specifically authorized to release to CWRU/Equity all information and records relating to such diagnosis, testing or treatment of any sexually transmitted diseases, HIV/AIDS, drug/alcohol/tobacco use, mental illness, and/or psychiatric treatment to the extent that such information is relevant to the condition for which I potentially need a workplace accommodation. I understand that the PHI may be released for purposes of, and may be used, reproduced, and disseminated in connection with my potential need for accommodations in the workplace.

3. I understand that the Providers cannot limit or control the subsequent use, reproduction, or dissemination of the Health Information or the PHI by the Institution, their Authorized Medical Consultant, or other third parties. I also understand that I may revoke this authorization in writing at any time, except to the extent that the Providers have taken action in reliance thereon. I hereby release the Providers from all legal responsibility that may arise from the use, reproduction, or dissemination of the Health Information or the PHI hereby authorized. I understand that treatment, payment, enrollment in a health plan or eligibility for benefits does not depend on me signing this Authorization.

4. This authorization is a free and voluntary act by me. A copy of this authorization is as valid as the original I understand that I must be provided with a copy of this authorization. This authorization is valid for 12 months from date of signature.

_____ _____

Date: (signature of patient or representative)

_____

(print name)