WILLIAMSON COUNTY BENEFITS ADMINISTRATION
AUTHORIZATION TO DISCLOSE HEALTH INFORMATION

Employee/Beneficiary Name _____ Date of Birth_____

Employee/Beneficiary Social Security Number _____

I _____ hereby authorize
(Employee, Beneficiary or Personal Representative)

Williamson County Benefits Administration of the Williamson County Government to disclose specific health information from the records of the above named employee or beneficiary to:

Any or all Physicians and /or Williamson County Governement, Human Resources.

(Recipient Name/Address/Phone/Fax)

_____

for the specific purpose(s): Disability and/or FMLA

_____

Specific information to be disclosed: Diagnosis

_____

_____

I understand that this authorization will expire on the following date, event or condition:

End of Disability

_____

I understand that if I fail to specify an expiration date or condition, this authorization is valid for the period of time needed to fulfill its purpose for up to one year, except for disclosures for financial transactions, wherein the authorization is valid indefinitely. I also understand that I may revoke this authorization at any time and that I will be asked to sign the *Revocation Section* of this form. I further understand that any action taken on this authorization prior to the rescinded date is legal and binding.

I understand that my information may not be protected from re-disclosure by the requester of the information; however, if this information is protected by the Federal Substance Abuse Confidentiality Regulations, the recipient may not re-disclose such information without my further written authorization unless otherwise provided for by state or federal law.

I understand that if my record contains information relating to HIV infection, AIDS or AIDS-related conditions, alcohol abuse, drug abuse, psychological or psychiatric conditions, or genetic testing this disclosure will include that information.

I also understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment, payment for services, or my eligibility for benefits; however, if a service is requested by a non-treatment provider (e.g., insurance company) for the sole purpose of creating health information (e.g., physical exam), service may be denied if authorization is not given. If treatment is research-related, treatment may be denied if authorization is not given.

I further understand that I may request a copy of this signed authorization.

_____	_____	Not Required
(Signature of Employee/Beneficiary)	*(Date)*	*(Witness-If Required)*
_____	_____	_____
(Signature of Personal Representative)	*(Date)*	*(Personal Representative Relationship/Authority)*

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NOTE: This Authorization was revoked on _____	_____
(Date)	*(Signature of Staff)*

REVOCATION SECTION

I do hereby request that this authorization to disclose health information of

_____
(Name of Employee or Beneficiary)

signed by_____ on _____
(Name of Person Who Signed Authorization) *(Date of Signature)*

be rescinded, effective _____. I understand that any action taken on this authorization prior to the rescinded date is legal and binding.

_____	_____	_____	_____
(Signature of Client)	*(Date)*	*(Signature of Witness)*	*(Date)*
_____	_____	_____	
(Signature of Personal Representative)	*(Date)*	*(Personal Representative Relationship/Authority)*	