



AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

I, _____, hereby authorize the use or disclosure of my health information for the purposes of my request for a leave of absence under ASU policy and/or the Family Medical Leave Act (FMLA).

1. I authorize the following health care provider/organization to provided this information:

2. I request the following information be provided (description of information):

Medical Certification

OR _____

I understand that:

- I have the right to revoke this authorization at any time by notifying Arizona State University (“ASU”) in writing. I understand that the revocation is only effective after it is received and logged the ASU. I understand that any use or disclosure made prior to the revocation under this authorization will not be affected by a revocation.
- Arizona State University (“ASU”) may use or disclosure protected health information about me for purposes of my request for a leave of absence under ASU policy and/or the Family Medical Leave Act (FMLA). I request to restrict use and disclosure of protected health information concerning health care treatment, payment, or health care operations about me by the ASU in accordance with the Health Insurance Portability and Accountability Act of 1996 (HIPPA).
- This authorization will expire when my employment with Arizona State University ends.
- I am entitled to receive a copy of this authorization.

Signature: _____

Date: _____

Personal Representative Section:

If a Personal Representative executes this form, that Representative warrants that he or she as authority to sign this form on the basis of the above-name employee in the following capacity _____.