WAKE FOREST UNIVERSITY

Human Resources

**HIPAA AUTHORIZATION REQUEST FORM**

I, _____, give WAKE FOREST UNIVERSITY written authorization to disclose my protected health information (PHI) to the individuals designated below for any purpose.

I understand that I may revoke this authorization at any time by giving WAKE FOREST UNIVERSITY written notice mailed to the address below. However, if I revoke this authorization, I also understand that the revocation will not affect any action WAKE FOREST UNIVERSITY took in reliance on this authorization before Wake Forest University received my written notice of revocation.

I also understand that if the persons or entities I authorize to receive my PHI are not health plans, covered health care providers or health care clearinghouses subject to the Health Insurance Portability and Accountability Act ("HIPAA") or other federal health information privacy laws, they may further disclose the PHI and it may no longer be protected by HIPAA or federal health information privacy laws.

At my request, I authorize WAKE FOREST UNIVERSITY to disclose Protected Health Information to (enter name of person/entity who will receive member's PHI):

_____

_____

_____

I authorize WAKE FOREST UNIVERSITY to disclose the following PHI to the person/entity listed above. CHECK ONLY ITEMS THAT APPLY:

___ Health information
___ Benefit plan information
___ Pay information

NOTE: WAKE FOREST UNIVERSITY will consider the effective date of this authorization to be the date WAKE FOREST UNIVERSITY received this signed document.

I would like this authorization to expire on (enter date): _____
(If no expiration date is provided, this authorization will expire twelve (12) months from the date of receipt.)

Name: _____

Signature: _____

Date: _____