

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

I _____ [Employee Name] hereby authorize the use or disclosure of my health information as described in this authorization.

(1) *Specific person authorized to provide the information:*

(2) *Specific person authorized to receive and use the information:*

(3) *Specific description of the information:*

(4) *Purpose of the request:*

(5) Right to revoke: I understand that I have the right to revoke this authorization at any time by notifying Brevard Public Schools in writing at Compensation and Benefits, 2700 Judge Fran Jamieson Way, Viera, Florida, 32940. I understand that the revocation is only effective after it is received and logged by Compensation and Benefits. I understand that any use or disclosure made prior to the revocation under this authorization will not be affected by a revocation.

(6) I understand that after this information is disclosed, Federal law might not protect it and the recipient might re-disclose it.

(7) I understand that I am entitled to receive a copy of this authorization.

(8) I understand that this authorization will expire when my employment with Brevard Public Schools terminates or at my written revocation of this request.

Signature of Employee: _____ Date: _____

4/03
8/03