AUTHORIZATION FOR DISCLOSURE OF EMPLOYMENT RECORDS

HIPAA Compliant

Employee Name: _____ **Date of Birth:**_____ **SSN:** _____

I hereby authorize the use or disclosure of the above named individual's employment information as described below:

Information to be released from:

Information to be sent to: **Lexitas**
307 29th Street NE, Ste 101
Puyallup, WA 98372
Phone: 253-445-3400 Fax: 253-445-4425
warecords@lexitaslegal.com

Information to be disclosed:

☐ Entire employment record, including, but not limited to, payroll, benefits, evaluations, applications, time loss, medical records.

☐ Entire employment record, including, but not limited to, payroll, benefits, evaluations, applications, time loss, medical records from _____to _____.

☐ Other _____

Purpose for which disclosure is being made:

☐ Attorney ☐ Insurance ☐ Doctor ☐ Personal

Employee/Patient authorization:
I understand that my records may contain information regarding the diagnosis or treatment of HIV/AIDS, sexually transmitted diseases, drug and/or alcohol abuse, mental illness, or psychiatric treatment. I give my specific authorization for these records to be released. **Exclude** the following information from the records released if initialed.

_____ Drug/alcohol abuse/treatment & diagnosis _____ Sexually transmitted disease

_____ HIV/AIDS diagnosis/treatment/testing _____ Mental illness or psychiatric diagnosis/treatment

My rights: I understand I do not have to sign this authorization in order to obtain health care benefits (treatment, payment or enrollment). I may revoke this authorization in writing. To view the process for revoking this authorization, please read the Privacy Notice to patients posted at the facility where your information is being released. I understand that once the health information I have authorized to be disclosed reaches the noted recipient, that person or organization my re-disclose it at which time it may no longer be protected under privacy laws.

Signature: _____ **Date:** _____
(Employee or authorized representative)

This authorization will expire 90 days from the date signed.
A copy of this authorization shall have the same force and effect as the original.