UConn Health

Authorization for Disclosure and Release of Medical Information Form

Revised 9/16

As required by Connecticut law, the Office of Institutional Equity may not use or disclose your individually identifiable information without your authorization.

Your completion of this form means that you are giving permission for the use(s) and disclosure described below.

Please review and complete this form carefully. It may be invalid if not fully completed.

Please forward this form, along with the Request for Reasonable Accommodation Form to the Office of Institutional Equity upon completion.

OIE USE ONLY

I, _____ [employee's name] whose home address is _____

and whose date of birth is _____HEREBY AUTHORIZE

_____

[provider's name and contact information]

to release medical information pertinent to the reasonable accommodation I requested to:

Office of Institutional Equity
UConn Health
263 Farmington Avenue
Farmington, CT 06030 - 5310
Telephone - (860) 679-3563
Facsimile - (860) 679-6512

To any licensed physician, other licensed practitioner, hospital, clinic, or other medically related facility, or United States Veteran Administration:

_____ I authorize you to release to the Office of Institutional Equity information to be used solely for the purpose of evaluating my request for reasonable accommodation.
Initial

This Authorization shall be valid for a period of 180 days after the date of my signature or earlier if revoked by me in writing to the Office of Institutional Equity.

_____
Initial

Acknowledgement

I understand that the Office of Institutional Equity may not use or disclose my medical information except for the expressed purposes identified above, unless another authorization is obtained from me or unless such use or disclosure is specifically required or permitted by law.

I understand that once this information is disclosed pursuant to this Authorization, it is no longer protected by the Office of Institutional Equity's privacy policies, and may possibly be re-disclosed by the recipient.

I hereby acknowledge that I have been informed of my right to receive a copy of this authorization request.

I acknowledge that I have the right to refuse to sign this Authorization.

I acknowledge that I may revoke this Authorization in writing at any time. I understand that if I revoke this Authorization, the information described above may no longer be used or disclosed for the purpose described in this written Authorization. To revoke this Authorization, please send a written statement to:

Office of Institutional Equity
UConn Health
263 Farmington Avenue
Farmington, CT 06030 - 5310
Telephone - (860) 679-3563
Facsimile - (860) 679-6512

My signature below indicates that I have read and understand this Authorization and its terms.

_____ _____
Signature Date