HIPAA RELEASE OF INFORMATION AUTHORIZATION FORM

I, ___________________________________ [Employee's Name] hereby authorize ______________________________________ [Healthcare Provider's Name] and its affiliates, its employees and agents to release to The University of the South Office of Human Resources all my personal health information relating to the diagnosis, treatment, and prognosis of my health condition for which I am seeking a job accommodation.

I understand that any personal health information or other information released to the person or organization identified above may be subject to re-disclosure by such person/organization and may no longer be protected by applicable federal and state privacy laws.

This authorization is valid from the date of my signature below and shall expire upon the termination of my employment with the University unless I revoke this authorization by providing written notice to the University's Office of Human Relations. However, this authorization may not be revoked if the University, its employees or agents have taken action on this authorization prior to receiving my written notice.

I also understand that I have a right to have a copy of this authorization.

Signature: _______________________________________

Date:______________________________