Appendix D

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

I ______________________________________ (Employee) hereby authorize the self-insured group health plan(s) offered by JEA to its workforce members (collectively, the "Plan") to use or disclose my health information as described in this authorization:

(1) List the person or organization authorized to receive/use information.

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(2) Provide description of health information to be released.

- o I authorize disclosure of all of my health information, including information relating to medical, pharmacy, dental, vision, mental health, substance abuse, HIV/AIDS, psychotherapy, reproductive, communicable disease and health care program information; or
- o I authorize only the disclosure of the following information:

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(3) Specific purpose of the disclosure:

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(4) *Right to revoke:* I understand that I have the right to revoke this authorization at any time by notifying the Privacy Officer in writing at JEA, Benefits Services, Attn: Privacy Officer, 21 West Church St., T-6, Jacksonville, FL 32202.

(5) I understand that the revocation is only effective after it is received and logged by JEA. I understand that any use or disclosure made prior to the revocation under this authorization <u>will not</u> 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 may not be denied treatment, payment for health care services, or enrollment or eligibility for health care benefits if I do not sign this form.

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

(9) I understand that this authorization will expire when my employment with JEA terminates.

____ ____________
Signature of Employee Date

Personal Representative Section

____________________________ ______________________
Name Phone Number

____________________________ ____________ ______ ______
Street Address City State Zip Code

____________________________ ______________
Signature of Guardian or Representative Date

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Basis of Authority for Guardian or Representative