Employee HIPAA Release Form

Date of Submission: _____

Employee Information:

- **Full Name: _____**
- **Employee ID: _____**
- **Contact Number: _____**
- **Email Address: _____**

Authorization Details:
I, [Employee Name], authorize the release of the following health information to [Name of Organization/Person]:

- **☐ Complete Medical Records**
- **☐ Specific Records: _____**
- **☐ Other (Specify): _____**

Purpose of Release:

- **☐ Employment Verification**
- **☐ Insurance Processing**
- **☐ Legal/Administrative Requirements**
- **☐ Other: _____**

Duration of Authorization:

- **Start Date: _____**
- **End Date: _____**

Acknowledgment of Rights:
I understand that:

- **I can revoke this authorization at any time by providing written notice.**

- **Refusal to sign this form will not affect my employment.**
- **Information disclosed may no longer be protected under HIPAA.**

Signature of Employee: _____

Date: _____

Witness (Optional):

- **Name: _____**
- **Signature: _____**