



Authorization for Release of Health Information

I _____ [Employee Name] hereby authorize the use or disclosure of my health information as described in this authorization.

(1) *Specific person/organization (or class of persons) authorized to provide the information:*

(2) *Specific person/organization (or class of persons) authorized to receive and use the information:*

Mercer University Human Resources or its designee

(3) *Specific and meaningful description of the information:*

[For example, medical examination report and conclusions related to a fitness-for-work exam, or results of drug testing for employment-related purposes.]

(4) *Purpose of the request:*

(Please state the purpose of the request below. If you do not wish to state a purpose, please state, "At the request of the individual.")

(5) *Right to revoke:*

I understand that I have the right to revoke this authorization at any time by notifying Mercer University in writing at Human Resources – 1400 Coleman Avenue – Macon, GA 31207. I understand that the revocation is only effective after it is received and logged by Mercer University. I understand that any use or disclosure made prior to the revocation under this authorization will not be affected by a revocation.

(6) I understand that after this information is disclosed, federal law might not protect it and the recipient might redisclose it.

(7) I understand that my Family and Medical Leave Act leave may be conditioned on my agreement to this authorization, and any additional authorization Mercer University requests.

(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 Mercer University terminates.

Signature of Employee _____ Date _____

Personal Representatives Section

If a Personal Representative executes this form, that Representative warrants that he or she has authority to sign this form on the basis of: _____