The University of Iowa Benefits Office
Personal Health Information Release Form

Please complete this form in its entirety. This release is not valid if it does not contain the employee's original signature and date signed or if it has expired as described below. This form will replace any that were previously submitted. Only those people listed on this form will have information released to them.

I hereby authorize: The University of Iowa Benefits Office
120 University Services Building, Suite 40
Iowa City, IA 52242

To disclose the following information from my benefit and health records:

Name: _____
Last, First MI

Address: _____
Street, City State, Zip

Birth date: _____/_____/_____ Telephone: _____ (Home)

Employee ID/University ID/SS#: _____ _____ (Work)

This information is to be disclosed to (please print the name of the person/s you want to be able to receive information):

_____

_____

Covering the periods: From: ____/____/____ To: ____/____/____
(If "To" is left blank, it is assumed to be an opened ended release.)

Affirmation of Release:

I give The University of Iowa Benefits Office permission to release my benefit and health information to the individual(s) or agency(s) I have named. I understand that this release is valid from the date I sign it and I may revoke this authorization at any time. Any revocation of this authorization will not affect my ability to obtain treatment or payment or my eligibility for benefits. The revocation will take effect on the day it is received in writing. I have the right to access the records of who has contacted the Benefits Office for information about me. Copies of the records may be obtained with reasonable notice and payment of copying costs.

_____ _____
Signature of the Employee Date Signed