

**AUTHORIZATION FOR THE RELEASE OF PERSONNEL RECORDS**

I, \_\_\_\_\_, hereby authorize the University of Iowa  
(Full name of employee)

**To release my Personnel records, as specified below, to:**

Name \_\_\_\_\_

Title/Organization \_\_\_\_\_

**I specifically authorize the release of the following Personnel file information:**

- Employment application
- Payroll/salary records
- Letters of Commendation/Discipline
- Performance evaluations
- Vacation use records
- Other: (Specify) \_\_\_\_\_
- All records in the departmental personnel file.

**This authorization shall be valid for a period of one year from the date of signature.**

\_\_\_\_\_  
Signature of Employee

\_\_\_\_\_  
Date of Signature

Note: The Authorization for the Release of Personnel Records shall be presented to a Human Resources representative or supervisor of the employee, and such releases shall become a part of the employee file.

**Specific Authorization for Release of Medical Information Contained  
Within my University of Iowa/UIHC Employment Records** (11/30/1999)

I, \_\_\_\_\_, hereby authorize the University of Iowa  
(Full name of employee)

To release medical information contained as part of my personnel file, as specified  
below, to: Name \_\_\_\_\_

Title/Organization \_\_\_\_\_

**I specifically authorize the release of the following medical information as may be  
contained as part of my personnel file:**

\_\_\_ Sick leave records, including verification statements of my medical condition  
\_\_\_ Family Medical Leave Act records on my family members, or myself as they  
relate to my employment.

\_\_\_ Departmental records of accommodation requests under the Americans with  
Disabilities Act and supporting documentation held in the department file

\_\_\_ Specific Work Injury Reports (List):

\_\_\_ Workers Compensation records

\_\_\_ Medical Leave requests and supporting medical information

\_\_\_ Other: \_\_\_\_\_

**Scope of Release:**

\_\_\_ Release the above noted records only as they relate to a specific time frame as  
specified: \_\_\_\_\_

**I authorize this release with full knowledge of the contents of the documents  
designated, which may include medical diagnoses and treatments. This  
authorization shall be valid for a period of one year from the date specified below.**

**\*Signature of Employee or Legal Representative:**

**Date:** \_\_\_\_\_

**SPECIFIC AUTHORIZATION FOR RELEASE OF INFORMATION  
PROTECTED BY STATE OR FEDERAL LAW**

**I specifically authorize the release of data and information related to:  
(Check the appropriate box)**

\_\_\_ **Substance Abuse**  
(alcohol/drug abuse)

\_\_\_ **Mental Health**  
(includes psychological testing)

\_\_\_ **HIV Related Information**  
(AIDS related testing)

\*Signature of Employee or Legal Representative: \_\_\_\_\_

Date: \_\_\_\_\_

\* Please note: In order for this information to be released, you must sign here and above and check the  
appropriate box (es).

Note: The Authorization for the Specific Release of Medical Information Contained within my Employment Records shall be presented to a Human Resources representative or supervisor of the employee, and such releases shall become a part of the employment related medical file.