RESET FORM

IOWA | University Human Resources
Benefits Office

PERSONAL HEALTH INFORMATION RELEASE FORM

THIS FORM IS OPTIONAL.

Please fill out this form in full. This authorization is not valid unless it includes the original signature and date of the employee, student, or retiree. It will also be considered invalid upon expiration, as outlined below. This form replaces any previously submitted authorizations. Only the individuals or agencies listed below will be permitted access to the requested information.

Employee/Student/Retiree Information

Full Name: _____

University ID Number: _____

Authorized Recipients

Full Name / Company: _____

Relationship to You: _____
(e.g., spouse, parent, child, attorney, financial advisor)

Additional Recipient (optional):

Full Name / Company: _____

Relationship to You: _____

Authorization Dates

From *(MM/DD/YY)*: _____

To *(MM/DD/YY)*: _____
Leave 'To' blank if you want this form to remain in effect indefinitely.

Affirmation and Authorization

By signing below, I give the University of Iowa Benefits Office permission to share my health and benefit information with the people or agencies I listed above. This permission starts on the day I sign this form and will stay in place unless I cancel it in writing. Canceling this permission will not change my benefits, treatment, or payments. I can ask for a record of who has received my information if I give reasonable notice.

Signature: _____ **Date:** _____

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