University
Human Resources
Benefits Office

PERSONAL HEALTH INFORMATION RELEASE FORM

This form is optional.

Please complete this form in its entirety. This release is invalid if it does not contain the employee or student's original signature and date signed or contain as described below. This form will replace any that was previously submitted. Only those people listed on this form will have information released to them. This form is available electronically within MyUI (students) or Employee Self-Service (employees).

Authorization

I, (employee/student full name) _____,

employee/student ID number _____ hereby authorize; the University of Iowa Benefits Office, 120 University Services Building, Iowa City, IA 52242, to disclose information from my benefit and health records to the individual(s) or Agency(s) named below:

Please print the name of the person/s you want to be able to receive information:

Full Name(s)/Company: _____

Relation to you: _____

Release Start and End Date *(leave "To" blank if you would like form to be open-ended)*

Cover the periods (print date MM/DD/YY):

From: _____ **To:**_____

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: _____ **Date:** _____

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