MY HR PROS

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Authorization for Use and Disclosure of Protected Health Information (PHI)

I authorize My HR Professionals to use and disclose my **Protected Health Information** as follows:

Participant
Name _____ SS#_____
Address_____ Birthdate_____

Authorized Person/organization to receive information:

Name_____ SS#_____
Address_____ Birthdate_____

Check applicable box for the type of information you authorize My HR Professionals to release:

☐ Benefits eligibility, enrollment selection, coverage type, payment of premiums or non-payment of premiums

☐ Participant Information only

☐ Dependent Information only

☐ Other (specify):_____

The participant MUST READ AND COMPLETE the following:

This authorization starts on (date)_____ and will expire on (date) _____.

I understand that I may revoke this authorization at anytime in writing. This authorization will be valid until that time. My HR Professionals is authorized to disclose this information to the authorized person until I notify them in writing to discontinue doing so or the authorization has expired.

_____ _____
Signature of participant Date