Letter of HIPAA Release

Employee			
	First Name	Last Name	Employee ID
	Title		
	Department		
	Home Phone		

To Whom It May Concern:

I, _____, hereby authorize you and/or any other hospital, clinic, center, medical institution, doctor or medical practitioner, insurance company, pharmacy, or employee of any of the above, to furnish and release to The University of Akron, or any of its authorized employees, representatives or agents, any and all reports, records, files, and information pertaining to my application for FMLA leave or sick leave. This Authorization includes, but is not limited to x-ray films, x-ray reports, pathology slides, tissue blocks, nurses' notes, emergency room records and bills for services. This Authorization also applies to alcohol, drug and psychiatric/psychological reports, records, files and information. The purpose of this release is to:

Obtain any medical information related to this request for FMLA or sick leave.

I waive and release any of the above sources or facilities from any restriction imposed by law thereof, in disclosing any record, observation, diagnosis or communication to The University of Akron or any of its authorized representatives or agents. I understand and agree that the information I have authorized to be released is exempt from the privacy requirements of the Health Information Portability and Accountability Act (HIPAA), pursuant to 45 CFR §164.512(e) and (l).

This Authorization is valid for one year from date hereof. I understand that a copy of this Authorization shall serve in lieu of the original.

Signature	Date