Employee Authorization for Release and Use of Protected Health Information
Health Insurance Portability and Accountability Act

Name of Plan (the "Plan"):	County of Cuyahoga Health and Welfare Plan
Name of Employer, or Plan Sponsor (the "Employer"):	County of Cuyahoga
Name of Authorized Person (if Applicable):	
Name of Employee and/or Covered Spouse or Dependent:	
Description of Claim or Medical Matter involved or Dates of Service or Provider Name:	

I am the Employee and/or Dependent whose name appears above. I hereby authorize and direct the release of all health and claim information for my claims under the Plan, referenced above, to my Employer and its authorized representatives (referenced above if applicable), including all persons at the Employer who are authorized to have access to Protected Health Information. I authorize the release of such information to my Employer and its insurance brokers, consultants, accountants, attorneys, advisors, and health care insurers, in connection with or in any way related to the above referenced claims, including electronic disclosure permitted under the Policy, for purposes of assisting me in addressing coverage, claims for benefits, or service matters related thereto.

I understand and acknowledge that the Information will be kept confidential and that I have the right to revoke this authorization, at any time, by notifying the Employer, in writing, of my wish to revoke this authorization. I acknowledge that when such revocation is received by the Employer, the Employer will no longer be involved in the matter of my health care claim and all files and records regarding the matter will either be returned to me, or destroyed. Any use or disclosure made prior to the revocation under this authorization will not be affected by a revocation.

Employee Acknowledgement and Authorization (Employee Must Sign):

Employee Signature:_____ Date:_____

If minor Dependent Claim or Matter is Involved:

I am the authorized Personal Representative of the above-named minor Dependent and I acknowledge this authorization on behalf of the minor Dependent listed above (may be the Employee):

Name (Print):_____ Signature:_____

Relationship:_____ (mother, father, guardian, other)

If Adult Spouse or Adult Dependent is Involved:

I am an adult Spouse or adult Dependent covered under Plan and I authorize the Employee identified here to be my representative regarding the disclosures of Protected Health Information hereunder and I further acknowledge, adopt and approve this authorization.

Name (Print):_____ Signature:_____