

**AUTHORIZATION FOR USE, DISCLOSURE OR RELEASE OF
PROTECTED HEALTH INFORMATION AND MEDICAL RECORDS FOR
EVALUATION UNDER THE AMERICANS WITH DISABILITIES ACT**

I hereby request and authorize the use, disclosure and/or release to Purdue University's Affirmative Action Office or Human Resource Services and its employees, of medical records or other protected health information as described below for the purpose of being evaluated under the Americans with Disabilities Act:

Employee's Name: _____

Employee's Address: _____
Street City State Zip

Phone Number: _____

Please identify who is to receive the medical records or other medical information:

Please describe specifically what medical records or other health information may be used or released:

This Authorization extends to such psychiatric, mental health, and drug and alcohol abuse treatment information, if any, as may be contained in said medical record including information protected by I.C. 16-39-1-9, and I.C. 16-39-2-1 through 16-39-4-2. This release permits re-disclosure in accordance with 42 C.F.R., Part 2, which is a federal regulation governing release and use of medical information pertaining to treatment for alcohol or drug abuse.

The Authorization also extends to information regarding communicable diseases, including human immunodeficiency virus (HIV), and AIDS related complex (ARC) and acquired immunodeficiency syndrome (AIDS), if contained in said medical record as indicated by I.C. 16-41-8-1.

I understand that upon release and disclosure of the protected medical records and information, the records and information may be subject to re-disclosure by the recipient and may no longer be protected by federal privacy regulations.

I understand that the covered entity will not deny treatment, payment, enrollment or eligibility for benefits based upon whether I sign this authorization. I also understand that an authorization may be necessary in order to process any request I have made for a release of medical records or other medical information. I may inspect or copy any information used or disclosed under this authorization.

I understand that I may revoke this authorization in writing at any time by mailing or delivering a written revocation to _____. The revocation will be effective upon receipt by the University, except to the extent that the University has taken action in reliance on this authorization. I further understand that, this authorization will expire as follows: (1) sixty (60) days from the Signature Date for all records except mental health records, and (2) one hundred eighty (180) days from the Signature Date for mental health records, unless I specify a different expiration date or event here: _____. After the expiration date, this authorization will no longer be effective, and no further information will be furnished pursuant to it.

Signed: _____
Employee

Date _____

Witness: _____

Date _____

Employee was offered a copy of this form and declined: