Authorization for Release of Information

I. Information about the Use or Disclosure

I hereby authorize the use of disclosure of my individually identifiable health information as described below. I understand that this authorization is voluntary and that I may refuse to sign this authorization, and that I may revoke it at any time by submitting my revocation in writing to the entity providing the information.

Employee name: _____ ID#: _____

Persons/organization authorized to provide the information: BAC, LLC

Person(s) authorized to request the information:

_____

Specific description of information to be used or disclosed:

_____

Specific purpose of the disclosure:

___ At the request of the individual, or,

___ For the following purpose:

_____

II. Expiration and Revocation

This authorization will expire _____ (Indicate a date, or an event relating to you personally or to the purpose of the authorization)

III. Important Information About Your Rights

I have read and understand the following statements about my rights:

- I may revoke this authorization at any time prior to its expiration date by notifying the providing organization in writing, but the revocation will not have any effect on any actions that the entity took before it received the revocation.
- I may see and copy the information described on this form if I ask for it.
- I am not required to sign this form to receive my health care benefits (enrollment, treatment, or payment).

IV. Employee's Signature

I, _____, have had full opportunity to read and consider the contents of this authorization, and I understand that, by signing this form, I am confirming my authorization of the use and/or disclosure of my protected health information, as described on this form.

Signature: _____ Date: _____