VILLAGE OF BUFFALO GROVE

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

I. Information About the Use or Disclosure of Protected Health Information (PHI)

Employee: _____ Address:_____ Date of Birth:_____
I (name of Employee, PSEBA Applicant or Patient), _____, hereby authorize the use or disclosure of my written, electronic and oral protected health information (PHI), as described in this authorization.

- I am authorizing the _____ ("Authorized Releasor(s)") to provide my health information.
- Please specify the individual/organization authorized to receive your health information:
  - ☐ Human Resources Division, Village of Buffalo Grove, Fifty Raupp Blvd., Buffalo Grove, IL 60089-2196

Name: _____ Daytime Tel: (_____) _____-_____

Address: _____

II. Description of Specific Information You Wish The Authorized Releasor To Disclose: (check all boxes that apply)

☐ PHI related to an illness or injury associated with a duty-disability pension award eligibility issued on _____/_____/_____.

☐ PHI related to an illness or injury identified in an application filed with the Village of Buffalo Grove for continued health coverage pursuant to the Illinois Public Safety Employee Benefits Act.

☐ Other: _____

State the purpose of this request below:

☐ To allow the recipient to make a determination of eligibility for benefits under the Illinois Public Safety Employee Benefits Act.

☐ Other: _____

(If you do not wish to state a purpose, please state "At request of the individual.")

This authorization will expire on: (If no date or occurrence specified, authorization will expire 1 year from date signed.)

☐ Give date or occurrence (Example: "When my PSEBA application case is resolved."):

_____

III. Important Information About Your Rights - I have read and understand the following statements about my rights:

- I understand that I have the right to revoke this authorization at any time by notifying the **Human Resources Division, Village of Buffalo Grove, Fifty Raupp Blvd., Buffalo Grove, IL 60089-2196**. I understand that the revocation is only effective after it is received and logged by the Human Resources Division. I understand that any use or disclosure made prior to the revocation under this authorization will not be affected by a revocation.
- I understand that after this information is disclosed, federal law might not protect it and the recipient might disclose it again.
- I understand that I am entitled to receive a copy of this authorization.
- I understand that I may refuse to sign this authorization and that my refusal to signed this authorization will not affect my ability to enroll in a health plan, obtain health care treatment or payment, or eligibility for benefits unless authorized by law.

IV. Signature of Participant or Beneficiary: _____ Date: _____

V. Personal Representative (If the person signing this form is the Personal Representative of the Employee/Patient, sign here.)
Personal Representative _____Date: _____

- I swear under penalty of perjury that I am the Personal Representative of the employee/patient named above.

Please state status (for example, parent, guardian, Power Of Attorney) _____
Print name of personal representative: _____ Day time Tel: (_____) _____-_____
Address: _____

If a personal representative executes this form, please attach copy of document, if applicable, which creates the status as personal representative, such as Legal Guardianship, General Power of Attorney, Power of Attorney for Health Care Matters.

Please return this form to: **Human Resources Division, Village of Buffalo Grove, Fifty Raupp Blvd., Buffalo Grove, IL 60089-2196**