HIPAA Authorization

A federal law known as the Health Insurance Portability and Accountability Act (HIPAA) protects how your health information is used. HIPAA does not allow your health information to be used or released for certain purposes without your written permission. By signing this form, you are allowing your health care providers to release your health information to the **University of Puget Sound Benefits Department** to evaluate your ability to return to work. You signature below authorizes your provider(s) to release information to the University Of Puget Sound Benefits Department after you complete the top portion of this form.

I hereby authorize my health care provider to release requested medical information to the University of Puget Sound Benefits Department up to the expiration date noted below.

Employee Signature _____ Date _____ Authorization Expiration Date _____

Release to Return to Work

The purpose of the release to return to work is to ensure that faculty and staff of the University of Puget Sound return to work safely following a medical leave of absence. Please have your medical provider complete this form and submit it to Human Resources via fax 253.879.2839 at least three days before your return to work date.

Patient Name: _____

Date(s) unable to work: From: _____ (MM/DD/YY) To: _____ (MM/DD/YY)

Date released to return to work: _____ (MM/DD/YY)

Is patient fully released to work? ☐ No ☐ Yes

Is patient released to work with restrictions? ☐ No ☐ Yes From: _____ (MM/DD/YY) To: _____ (MM/DD/YY)

Please list in detail any work-schedule restrictions or limitations:

_____

_____

_____

If patient is not yet released to return to work without restrictions, when is patient's next appointment to evaluate his/her condition and work restrictions? _____ (MM/DD/YY)

Physician Name: _____ Phone: _____

Address: _____

Physician's Signature _____ Date _____