



**CITY OF LINCOLN
LONG TERM DISABILITY AUTHORIZATION
FOR DISCLOSURE OF HEALTH INFORMATION**

Name _____ Phone Number _____

Address _____

City _____ State _____ Zip _____

I am either the patient named above or the patient's legally authorized representative.
By signing this form, I *authorize* the following medical provider(s):

To disclose my protected health information to the individuals or organizations listed below:

CITY OF LINCOLN

The specific type of information to be disclosed shall consist of true, correct, and complete copies of all medical records of any kind, including, but not limited to, medical reports, consultation reports, doctors' notes, nurses' notes, correspondence, and documentary material of any kind, including but not limited to drug or alcohol records and health information related to psychological or psychiatric conditions, including psychotherapy notes, relating in any way to treatment of the above described patient rendered by the above described provider.

The purpose and need of such disclosure is to receive long term disability (LTD) benefits.

Expiration: Without express revocation, this consent shall expire one year from the date of this authorization.

Revocation: I understand that I may revoke this consent by providing written notice to the above mentioned provider at any time except to the extent that the provider has taken action in reliance on this authorization. I may revoke the consent by providing a written notice to the Provider listed above.

Prohibition of Conditioning of Treatment: I understand that the provider's treatment to me is not contingent upon my decision to provide or withhold consent or release information.

Further Uses and Disclosures: I understand that there is a potential for information disclosed pursuant to this authorization to be subject to redisclosure by the recipient and no longer be protected by federal privacy laws.

I understand that a photocopy or a faxed copy of this authorization will be considered as valid as the original.

Printed Name (Employee/Patient)

Date of Birth

Signature (Employee/Patient)

Social Security Number

Date _____