M-DCPS Office of Risk and Benefits Management Authorization for Use and Disclosure of Private Health Information

I, _____ hereby authorize Miami Dade County
(Employee Name and Employee Number)
Publics Schools – Office of Risk and Benefits Management agents, employees and associates to use and disclose (release) my protected health information. This authorization includes the right to claims, enrollment, billing and/or eligibility information.

To authorize the use and disclosure of your protected health information to an individual and/or organization, please provide their information below.

_____
(Specific person(s) and relationship(s)/organization name)

Conditions:

- The employee will retain a copy of the signed authorization for their records.
- The employee reserves the right to refuse to sign this authorization. Enrollment, treatment, payment or eligibility for benefits will not be affected.
- The Office of Risk and Benefits Management will release only the minimum amount of information necessary to fulfill a request.
- The employee reserves the right to revoke this authorization at any time. This revocation must be in writing and sent to risk@dadeschools.net.

I have read and understand the above information:

_____ _____
Signature of Employee/ Personal Representative Date

Personal Representative's Authority: _____
(copy of Durable Power of Attorney, Designation of Health Care Surrogate, etc. must be provided)

This Authorization for Use and Disclosure of Private Health Information will expire 90 days from the date of signed authorization.

Revised: 5/1/2023