As required by the Health Insurance Portability and Accountability Act of 1996, the J.R. Simplot Company Group Health and Welfare Plan may not use or disclose your health information, except as provided in our Notice of Privacy Practices, without your authorization. Your signature on this form indicates that you are giving permission for the uses and disclosures of protected health information described herein.

Authorization for the Use or Disclosure of Protected Health Information

1. Your Name: _____ **2.** SSN or ID# _____ **3.** Date of Birth ____/____/____

4. Mailing Address: _____
Street City State Zip

I hereby authorize the use or disclosure of my protected health information as described below. I understand that I may refuse to sign this authorization. I understand that I may revoke this authorization at any time by signing and dating the revocation section at the bottom of this form and returning to the J.R. Simplot Company Group Health and Welfare Plan Privacy Officer. I understand that the revocation will not have any effect on any actions that the entity took before it received the revocation. Further, I declare this authorization is voluntary, and I acknowledge that my signature below is not a condition for enrollment, treatment, payment or eligibility under the Plan.

I authorize the following person and/or entity to ***disclose*** my protected health information (as specified below):
HIPAA Workforce of the J.R. Simplot Company Group Health & Welfare Plan

5. I authorize the following person and/or entity to ***receive*** these disclosures of my protected health information:

Name _____

Entity/Organization (if applicable) _____

Relationship _____

Full Address _____

Phone/fax/email (if applicable) _____

6. Here is a description of the information to be used or disclosed: (please select only one)

- ☐ Any and all personal health information for all dates of service
- ☐ Any and all personal health information between the dates of _____ and _____
- ☐ Photocopies of records only (please specify)
- ☐ Other (please specify) _____

7. Here is a description of the purpose of the disclosure:

- ☐ Per my request
- ☐ Other (please specify) _____

8. This authorization expires on:

- ☐ Upon termination of my participation in the Plan
- ☐ _____
  Date

9. Signature Section

I understand that I have a right to request, obtain and inspect a copy of any information disclosed pursuant to this authorization. I understand that information used or disclosed, pursuant to this authorization, could be subject to redisclosure by the recipient and, if so, may not be subject to federal or state law protecting its confidentiality.

X _____ _____
Signature – Individual Participant or Authorized Personal Representative date

_____
If signed by Authorized Personal Representative, print name and relationship to participant

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Revocation Section: I hereby revoke this authorization

_____ _____
Signature – Individual Participant or Authorized Personal Representative date

_____ _____
Privacy Officer or Designee Signature date

Return this form to the HIPAA Privacy Officer, J.R. Simplot Company, P.O. Box 27, Boise, ID 83707
Phone number: (208) 780-7500