UNIVERSITY OF NEBRASKA
FULLY-INSURED GROUP HEALTH PLAN
AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

______________________________	______________________________
Employee Name	**University ID Number**

INDIVIDUAL AUTHORIZING RELEASE OF PHI

COVERED/INSURED PERSONôS NAME____ **D.O.B.**________________

ADDRESS____________________________________ **PHONE #**___________________ **S.S. #**_ _ _ - _ _ - _ _ _ _

I hereby authorize the disclosing party listed below to use and/or disclose my Protected Health Information (PHI) as follows: