PF HOLDINGS

Authorization to Release Confidential Employment & Personal Health Information

Employee Name:	Employee ID #	Department:
Date :	Title:	

Part I – Confidential Employment Information

I hereby authorize PF Holdings to release any and all information regarding my employment with PF Holdings.

Yes_____ No _____

Part II – Personal Health Information

I hereby authorize the use and disclosure of my individually identifiable health information as described below for the purpose of providing PF Holdings with an alternate contact other than me.

I understand that signing this authorization is voluntary and that if I refuse to sign this form it will not prevent receipt of health care or eligibility for benefits under a health plan.

I understand that I am entitled to receive a copy of this form upon signing it.

I understand that if the organization or individual authorized to receive the information is not a health plan or health care provider; the released information may no longer be protected by federal privacy regulations.

I understand that I have a right to revoke this authorization, but that I must send a written revocation to the address below. I also understand that the revocation applies to uses and disclosures made after the revocation is made.

Yes_____ No _____

Specific description of information that is to be disclosed (if everything can be disclosed, please write the word ‘all” below in description box below):

Person Authorized To Receive My Information

Name	Phone Number

Employee Signature	Date