Authorization For Release of Information

The privacy provisions of the Health Insurance Portability and Accountability Act (HIPAA) issued and enforced by the Department of Health and Human Services provide the standards for the protection of the privacy of personal health information and allow for an individual to authorize the use and disclosure of the individual's personal health information in circumstances where HIPAA would otherwise limit such use or disclosure. By completing and signing this form, I hereby authorize the employees of the Autodesk Benefits Department and its insurance carriers with respect to the health plan component of the Autodesk, Inc. Group Welfare Benefit Plan to receive and disclose my individually identifiable health information for the purpose described below to the individual or entity identified below:

Enter detailed description of information allowed for disclosure (for example, "information related to my claim incurred on June xx, 2016), including who the disclosure can be made to:

Purpose of the requested use or disclosure:

Person or organization authorized to receive my health information (insert name and address):

Describe information to be used or disclosed (e.g., information related to my claim incurred on –insert date) (Note: If the information to be used or disclosed relates to mental health/substance abuse care or treatment or to HIV care and treatment, I understand that my description must state that I specifically authorize the party above to receive such mental health/substance abuse care or treatment or HIV care/treatment information):

Describe any limitation on the use or disclosure, if any:

I UNDERSTAND THAT THIS AUTHORIZATION IS VOLUNTARY AND MAY BE REVOKED AT ANY TIME BY SUBMITTING A WRITTEN REVOCATION TO THE AUTODESK BENEFITS DEPARTMENT (see further details below). I understand that the Autodesk, Inc. Group Welfare Benefit Plan may not use or disclose my individually identifiable health information under HIPAA and as described in the Notice of Privacy Practices for the purpose listed above without my written authorization.

My signature below confirms that I have read and understand the information and authorize the receipt, use and disclosure of the information described in this document.

- Information disclosed under this authorization may be redisclosed by the recipient and no longer protected by federal privacy regulations. I further understand that I have the right to receive assurances from the receiving entity that they will not re-disclose the information to any other party without my further authorization. However, any information disclosed to health care providers, insurance companies, insurance agents and brokers, health plans and health plan administrators will continue to be protected and not be reused or redisclosed other than as authorized by me or permitted by law.

- Enrolling in benefits plans, determining eligibility for benefits, receiving treatment and processing payments for services will not be affected if I do not sign this form. However, without my signature, my requests to release information for my benefit will not be honored.
- I may receive a copy of this form if I request it by writing to the address listed at the bottom of this page.
- This authorization is valid from the date I sign this “Authorization For Release of Information” Form and will expire six months after the signature date.
- If I sign this form, I retain the right to revoke the authorization at any time by notifying the Autodesk Benefits Department in writing at the address below. Revoking this authorization will not have any effect on actions that Autodesk took in reliance on the authorization before Autodesk’s Benefits Department received the notification. Such revocation must adequately describe this Authorization and include this Authorization’s effective date.

____ ____________________
Print Employee Name Employee ID #

____
Print Patient Name

____ ____________________
Patient/Employee Signature Date

Return this completed form to: Autodesk Benefits Department
111 McInnis Parkway
San Rafael, CA 94903
Fax: 415-507-6121